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ABSTRACT

In compliance with government regulations, this compilation of materials and bibliographic references has been prepared by the Library of Congress to assist debaters in researching the 1993-94 national debate topic for high schools which deals with access by all U.S. citizens to health care. The compilation which was assembled after a review of a wide spectrum of opinions as reflected in current literature, is divided into four main sections. The first presents general materials such as strategy and position paper, presidential remarks, and health care fact sheets and summaries. The next three sections deal with each of three possible debate propositions or resolutions, namely: that the Federal Government should guarantee comprehensive national health insurance to all U.S. citizens; that the Federal Government should control health care costs for all U.S. citizens; and that the Federal Government should guarantee catastrophic health insurance to all U.S. citizens. The compilation concludes with an extensive annotated bibliography presented in four sections corresponding to the four sections of the document paper. A guide to other information sources on the debate topic, as well as a list of other available government publications on the topic, are also provided. (NKA)

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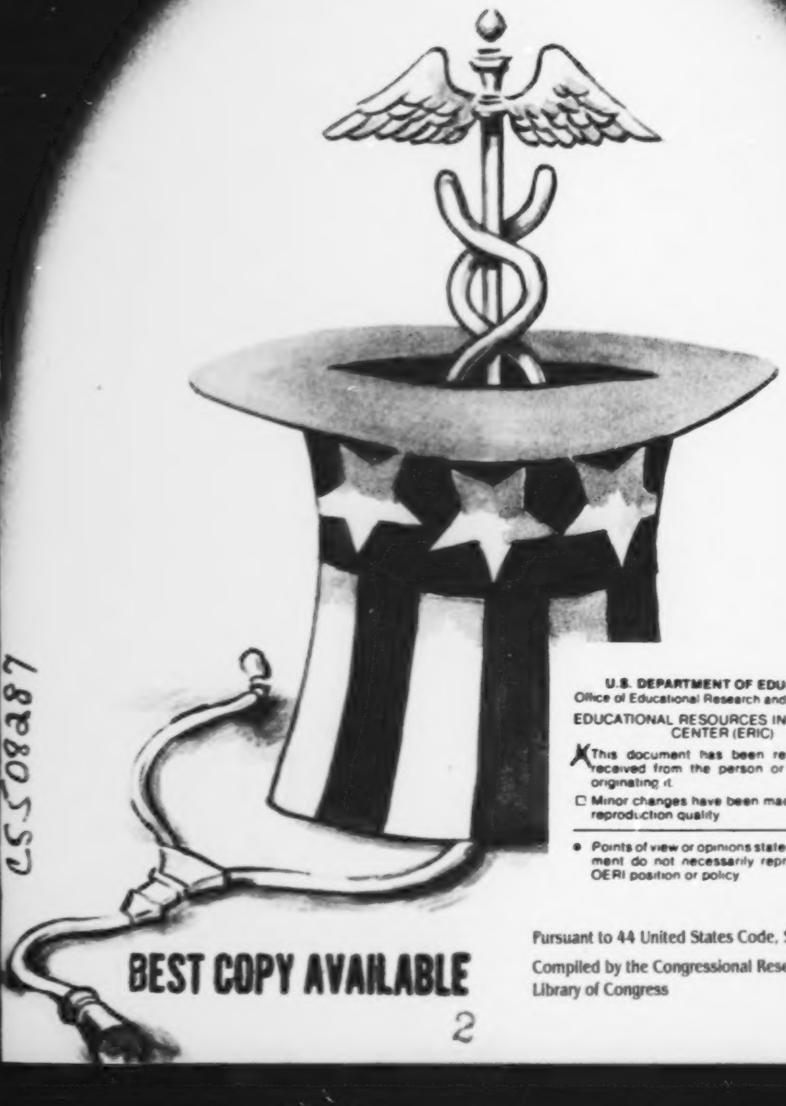
ED 361 775

103d Congress, 1st Session, Senate Document 103-2

National Debate Topic for High Schools, 1993-94

# NATIONAL HEALTH CARE

How can the Federal Government increase access to health care to United States citizens?



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103d Congress, 1st Session / Senate Document 103-2

National Debate Topic for High Schools, 1993-94

# NATIONAL HEALTH CARE

## How can the Federal Government increase access to health care to United States citizens?

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(Pub. L. 90-620, Oct. 22, 1968, 82 Stat. 1270.)

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CRS Congressional Research Service • The Library of Congress • Washington, D.C. 20540

March 31, 1993

## FOREWORD

The 1993-1994 high school debate topic is "How can the Federal Government increase access to health care to United States citizens?" The three official debate propositions within this topic are:

| | |
|---|---|
| **RESOLVED:** | That the Federal Government should guarantee comprehensive national health insurance to all United States citizens. |
| **RESOLVED:** | That the Federal Government should control health care costs for all United States citizens. |
| **RESOLVED:** | That the Federal Government should guarantee catastrophic health insurance to all United States citizens. |

In compliance with 44 U.S. Code, section 1333, the Congressional Research Service of the Library of Congress prepared this compilation of materials and bibliographic references to assist college debaters in researching the topic. In selecting items for this manual, the Congressional Research Service (CRS) has sampled the wide spectrum of opinions reflected in current literature on these questions. No preference for any policy is indicated by the selection or positioning of articles cited, nor is CRS disapproval of any policy or article to be inferred from its omission.

A research guide is included at the end of this volume; it is intended to help debaters identify further references and organizational resources on their own. Also included is a list of relevant publications that are available for purchase from the Superintendent of Documents, Government Printing Office. Some of the U.S. Government documents listed in the manual may be found in U.S. Government depository libraries, which can be identified by local public libraries. The Library of Congress cannot distribute copies of these or other materials to debaters.

The documents presented in this compilation were selected by M. Alexandra Salinas, Senior Bibliographer, Education and Public Welfare, of the Library Services Division, with assistance from the Health Section of the Education and Public Welfare Division of CRS. Ms. Salinas also prepared the bibliography and guide to information sources. Production was made possible by C. Lee Burwasser, Library Services Division. Thanks are extended to Kristin M. Vaje, Head, Subject Specialization Section, Library Services Division, and William G. Kaye of the CRS Review Office, for their review.

Good luck to each debater in researching, preparing, and presenting arguments on this year's topic.

Joseph E. Ross

Joseph E. Ross, Director

# GENERAL MATERIALS

**FOR IMMEDIATE RELEASE**
**Monday, January 25, 1993**

## PRESIDENT CLINTON FORMS HEALTH CARE TASKFORCE

WASHINGTON, D.C. -- In effort to develop a plan for high quality, affordable health care for all Americans, the President today announced the formation of a taskforce to develop legislation for comprehensive health care reform.

"It's time to make America's health care system make sense. It's time to bring costs under control -- so that every family can be secure in the thought that a medical emergency or a long illness will not mean bankruptcy," the President said. "And it's time to bring quality coverage to every American -- to cut back on the paperwork and the excuses and make health care a right, not a privilege."

The President's taskforce, which is expected to report a plan by the end of May, will be chaired by First Lady Hillary Rodham Clinton. The health care taskforce will include Secretary of the Treasury Lloyd Bentsen, Secretary of Defense Les Aspin, Secretary of Commerce Ron Brown, Secretary of Labor Robert Reich, Secretary of Health and Human Services Donna Shalala, Secretary of Veterans Affairs Jesse Brown, Office of Management and Budget Director Leon Panetta, Assistant to the President for Domestic Policy Carol Rasco, Assistant to the President for Economic Policy Robert Rubin, Council of Economic Advisors Chair Laura Tyson and Senior Advisor to the President for Policy Development Ira Magaziner.

Magaziner will lead an interdepartmental working group which will coordinate policy development for the taskforce. Health care transition director Judith Feder will assist Magaziner and other senior transition officials will be members of the working group.

The taskforce will work cooperatively with members of Congress as well as with state, city and county officials in developing its proposals. It will conduct an outreach program to seek verbal input and formal written submissions from interested citizens and groups across the country.

The process will seek advice from people like the many the President met during the campaign, for whom rising health care costs and lack of adequate health care coverage are causing severe hardship.

-- more --

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The President said the legislation will be based on the following principles:

- To slow the growth of national health care spending.
- To provide universal access to high quality care for all Americans.
- To ensure consumer choice.
- To maintain a private, competitive health care system.
- To cut the health care bureaucracy.

While her husband was Governor of Arkansas, Mrs. Clinton chaired the Arkansas Education Standards Committee, which in 1984 created public school accreditation standards that have since become a model for national reform. In 1984-1985, Mrs. Clinton served as her husband's designee on the Southern Regional Taskforce on Infant Mortality. She served as the chair of the Arkansas Rural Health Committee in 1979-1980, and has served on the board of the Arkansas Children's Hospital, where she helped establish the state's first neo-natal unit. In addition, Mrs. Clinton introduced a pioneering program that trained parents to work with their children in pre-school preparedness and literacy through Arkansas' Home Instruction Program (HIPPY).

Reprinted from the Press Conference by President Bill Clinton announcing the formation of the President's Task Force of Health Care Reform. Jan 25, 1993.
2 p.

The Taskforce expects to release its report with proposals in May 1993.

## QUALITY, AFFORDABLE HEALTH CARE

The American health care system costs too much and does not work. Instead of putting people first, the government in Washington has favored the insurance companies, drug manufacturers, and health care bureaucracies. We cannot build the economy of tomorrow until we guarantee every American the right to quality, affordable health care.

Washington has ignored the needs of middle class families and let health care costs soar out of control. American drug companies have raised their prices three times faster than the rate of inflation, forcing American consumers to pay up to six times more than Canadians or Europeans for the same drugs. Insurance companies routinely deny coverage to consumers with "pre- existing conditions" and waste billions on bureaucracy and administration. Twelve years ago Americans spent $249 billion on health care. This year we'll spend more than $800 billion.

Health care costs are now the number one cause of bankruptcy and labor disputes. They threaten our ability to compete, adding $700 to the cost of every car made in America. Our complex system chokes consumers and providers with paper, requiring the average doctor to spend 80 hours a month on paperwork. It invites fraud and abuse. We spend more on health care than any nation on earth and don't get our money's worth.

Our people still live in fear. Today almost 60 million Americans have inadequate health insurance — or none at all. Every year working men and women are forced to pay more while their employers cover less. Small businesses are caught between going broke and doing right by their employees. Infants die at rates that exceed countries blessed with far fewer resources. Across our nation older Americans live in fear that they will fall ill — and lose everything or bankrupt their children's dreams trying to pay for the care they deserve.

America has the potential to provide the world's best, most advanced and cost-effective health care. What we need are leaders who are willing to take on the insurance companies, the drug companies, and

**Reprinted from Putting People First: a National Economic Strategy for America. Little Rock, Ark., Bill Clinton for President Committee, 1992. p. 17-19.**

the health care bureaucracies and bring health care costs down.

My health care plan is simple in concept but revolutionary in scope. First, we will move to radically control costs by changing incentives, reducing paperwork and cracking down on drug and insurance company practices. As costs drop, we will phase in guaranteed universal access — through employer or public programs — to basic medical coverage. Companies will be required to insure their employees, with federal assistance in the early years to help them meet their obligations. Health care providers will finally have incentives to reduce costs and improve quality for consumers. American health care will make sense.

My plan will put people first by guaranteeing quality, affordable health care. No American will go without health care, but in return everyone who can must share the cost of their care. The main elements include:

- National spending caps. The cost of health care must not be allowed to rise faster than the average American's income. I will scrap the Health Care Financing Administration and replace it with a health standards board — made up of consumers, providers, business, labor and government — that will establish annual health budget targets and outline a core benefits package.

- Universal coverage. Affordable, quality health care will be a right, not a privilege. Under my plan, employers and employees will either purchase private insurance or opt to buy into a high-quality public program. Every American not covered by an employer will receive the core benefits package set by the health standards board.

- Managed care networks. Consumers will be able to select from among a variety of local health networks, made up of insurers, hospitals, clinics and doctors. The networks will receive a fixed amount of money for each consumer, giving them the necessary incentive to control costs.

- Eliminate drug price gouging. To protect American consumers and bring down prescription drug prices, I will eliminate tax breaks for drug companies that raise their prices faster than Americans' incomes rise.

- Take on the insurance industry. To stand up to the powerful insurance lobby and stop consumers from paying billions in administrative waste, we need to streamline the industry. My health plan will institute a single claim form and ban underwriting practices that waste billions to discover which patients are bad risks. Any insurance company that wants to do business will have to take all comers and charge every business in a community the same rate. No company will be able to deny coverage to individuals with pre-existing conditions.

- Fight bureaucracy and billing fraud. To control costs and trim the "paper hospital," my plan will replace expensive billing, coding and utilization review functions with a simplified, streamlined billing system. Everyone will carry "smart cards" coded with his or her personal medical information. We will also crack down on billing fraud and remove incentives that invite abuse.

- Core benefits package. Every American will be guaranteed a basic health benefits package that includes ambulatory physician care, inpatient hospital care, prescription drugs, and basic mental health. The package will allow consumers to choose where to receive care and include expanded preventive treatments such as pre-natal care, mammograms and routine health screenings. We'll provide more services to the elderly and the disabled by expanding Medicare to include more long-term care.

- Equal costs. All businesses, regardless of size, will pay a set amount per person they employ. This system, known as "community rating," will protect small businesses and spread the risk evenly among all companies.

United States General Accounting Office

GAO Transition Series

Reproduced from U.S. General Accounting Office. Transition Series.
Health care reform. 1992. p. 1-31.

GAO/OCG-93-6TR

December 1992

# Health Care Reform

GAO United States
General Accounting Office
Washington, D.C. 20548

Comptroller General
of the United States

December 1992

The Speaker of the House of Representatives
The Majority Leader of the Senate

In response to your request, this transition series report discusses major policy, management, and program issues facing the Congress and the new administration in the area of health care reform. The issues include (1) access to health insurance for the uninsured, (2) private health insurance market reforms, (3) health care cost containment, (4) administrative simplification, (5) fraud and abuse controls, (6) diffusion and pricing of new medical technologies, and (7) medical malpractice reform.

As part of our high-risk series on program areas vulnerable to waste, fraud, abuse, and mismanagement, we are issuing a related report, Medicare Claims (GAO/HR-93-4, Dec. 1992).

The GAO products upon which this transition series report is based are listed at the end of this report.

We are also sending copies of this report to the President-elect, the Republican leadership of the Congress, the appropriate congressional committees, and the Secretary-designate of the Department of Health and Human Services.

Charles A. Bowsher

Charles A. Bowsher

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# Health Care Reform

A key challenge facing the new Congress and administration is finding a better way to manage and finance the U.S. health care system while preserving the high-quality, innovative medical care the United States has achieved. The United States is projected to spend 18 percent of its gross domestic product (GDP) on health care by the year 2000 —far more than any other industrialized country. These growing costs are being shared by individuals and the business community as well as federal and state programs. The inexorable rise in health care costs is constraining wage increases and the financial capability of federal and state governments to address other pressing social concerns. We have emphasized that failure to control overall health care costs will stymie efforts to control outlays on Medicare and Medicaid—the fastest growing major programs in the federal budget—and will make it more difficult, if not impossible, to bring the federal budget into balance. [1] Individuals, business, and the government need to work together to tame the cost spiral for health care.

Despite having the highest costs in the industrialized world, our health care system is not serving large portions of our population very well. Nearly 34 million Americans are uninsured and millions more are underinsured or fear they might lose coverage if they develop a serious medical condition, lose their job, or change employers.

The Congress has asked us to review approaches developed in American communities and foreign countries that might help explain the root causes of our health care problems and suggest possible solutions. We have examined the experiences of Canada, France, Germany, and Japan as well as U.S. federal programs and state and community initiatives. If the United States is to broaden access and contain health spending, there is a need to consider adopting features common to successful systems that we have observed in other countries and within our own borders.

A reformed U.S. system must also build on the strengths of the nation's current health care system. A strong research establishment, the continuing development of technology, and the capacity to evolve more efficient service delivery mechanisms are among the strengths of the U.S. health care system that should be preserved.

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[1] See particularly app. III in Budget Deficit: Appendixes on Outlook, Implications, and Choices (GAO/OCG-90-5A, Sept. 28, 1990).

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# Access to Health Insurance for the Uninsured

Universal access to health insurance is an achievable goal. Countries like Canada, France, and Germany provide high-quality health care to all their citizens, yet spend a considerably smaller share of their nations' resources on health. Within our own borders, Hawaii is the state with the largest share of its population covered by health insurance. Rochester, New York, counts 7.1 percent of its population under the age of 65 as uninsured compared with a national average of about 15 percent. Yet both Hawaii and Rochester have achieved enviable records in terms of health cost containment and the level of insurance premiums.

Universal access to health insurance is not free. Estimates for providing the 34 million persons who are uninsured with health insurance range from $12 billion to $27 billion annually. These costs are not the only factor that has made it difficult to achieve universal access to health insurance in the United States. Universal access would also entail major changes in the role of government, the structure of the health finance system, and the financial responsibilities of individuals and employers. An employer mandate would compel businesses to provide or finance insurance for their employees and may add new costs and responsibilities for many small firms. A Canadian-style system would involve a substantial increase in the share of health care costs financed through the tax mechanism.

The United States is considering a commitment to universal coverage not only because of the needs of the 34 million uninsured but also because such coverage can contribute to both short- and long-term strategies for cost containment. Universal coverage contributes to lowering administrative costs for providers by relieving them of the burden of assessing insurance status before treatment and by limiting losses associated with bad debt. Changes in these two areas would be especially beneficial for institutions such as teaching hospitals and public hospitals in large cities that currently serve large numbers of uninsured patients. Universal coverage also contributes to system efficiency by reducing the need for the uninsured to use more expensive treatment settings such as the hospital emergency room because they are not covered for treatment in less expensive settings. Moreover, adequate coverage for preventive and primary care for chronic conditions can help avoid more costly and serious treatments in the future.

Universal health insurance coverage is not ensured in all of the comprehensive reform proposals, although all proposals seek to make significant inroads to reducing the uninsured population. National health insurance plans that cover all citizens explicitly solve the problem of the uninsured. Proposals that rely on the existing employer-based insurance model require development of complementary programs to cover the uninsured who are not employed and any employed persons or family members who remain uninsured under the employer-based plans.

For example, Hawaii's mandate that employers provide insurance coverage does not require that health insurance coverage be provided to part-time workers or to family members of insured workers. To address these gaps in coverage and to include the unemployed who are not eligible for Medicaid, Hawaii developed a supplemental state-sponsored insurance plan to extend coverage to these groups. The state estimates that it has reduced the number of uninsured to about 2 percent of its population.

# Private Health Insurance Market Reforms

About three-fourths of uninsured Americans are workers or their dependents, and just over one-half of uninsured workers are employed by firms with fewer than 25 employees. Some underwriting and rating practices in the private insurance industry have made obtaining affordable health insurance difficult or impossible under several conditions: when an insured worker, dependent family member, or coworker in the same risk pool develops an expensive medical condition; when a worker changes jobs; or when a firm changes insurance carriers. If comprehensive reform is based on the current employer-based private insurance system, reforms of insurance practices that affect people in these situations are essential.

Two broad types of health insurance reforms would be needed—those designed to improve availability and those designed to improve affordability. Reforms related to availability guarantee that insurance will be available to all eligible members of employee groups through

- guaranteed issue of policies to all employer groups and their eligible members,

- guaranteed renewal of policies that eliminate or restrict the capacity of insurers to cancel policies because of medical history or to introduce new policy exclusions at the time of renewal, and

- guaranteed continuity of coverage when employers change insurers, employees change jobs, or insurers become insolvent or discontinue offering health insurance.

Because insurance may be available but still priced out of the reach of small businesses, affordability also needs to be addressed through

- restricting factors used in setting rates, such as health status and previous claims experience, and

- limiting the range of premiums a single insurer can charge for customers with different risk characteristics.

These types of reforms are needed to ensure that private insurance products are available to everyone under employer-mandated coverage plans. However, such reforms can be a double-edged sword. While they would increase availability and reduce insurance premiums for higher-risk groups that have been excluded from the market, the reforms would generate higher premiums for those currently insured in lower-risk groups who would share in the costs of the extended coverage.

The net effect of insurance market reforms alone on reducing the ranks of the uninsured is unclear. States have introduced a number of these reforms in the last few years. Early experience suggests that such reforms have had a modest effect on reducing the ranks of the uninsured when coupled with limited subsidy programs and state assistance to risk pooling.

# Health Care Cost Containment

The call for control of health care costs is now heard throughout U.S. society. Expanding insurance coverage to the uninsured would make cost control more urgent, but even without that additional spending, the upward sweep of health care costs is threatening the financial position of businesses, individuals, and governments.

Cost control entails some force that disciplines the decisions of consumers and providers. As a result, cost control means that some segments of society will receive less. Providers (such as physicians and hospitals) will have lower revenues than if present trends continue. Consumers may face less choice among providers, and the rate of improvement in medical technology may slow.

Nonetheless, cost control is imperative. Without it, the problem of the uninsured will likely worsen as the unchecked rise in the cost of insurance puts it out of the reach of more and more people. Moreover, lack of cost control will aggravate the budgetary squeeze on the federal and state governments. How to control costs with the fewest adverse effects on the population is the challenge.

Among the many proposals for achieving cost discipline in U.S. health care, two broad strategies are currently most prominent: managed competition and direct controls. Both would use government regulation, although in quite different ways. The two strategies differ in the extent to which they rely on market forces and in the extent to which they have been tested in practice. Managed competition would give regulation a competition-enhancing slant by establishing a complex set of rules within which competition can occur. After restructuring the marketplace, the government would play umpire for insurers, providers, and beneficiaries while letting competition exert discipline and rein in health care costs. The second strategy, direct controls, would require public (or quasi-public) authorities to set health care prices, limit overall spending, and regulate the spread of new technology.

The strategy of managed competition is evolving, and its various proponents sometimes define it in different ways. Nonetheless, they agree on blending federal regulation with incentives and private initiative to create a cost-conscious discipline for hospitals and physicians. Also, current proposals assume heavy reliance on managed care health plans, such as health maintenance organizations (HMO) and preferred provider organizations (PPO), that try to encourage efficiency by placing providers at risk for health costs, using administrative processes to attempt to control services, or both.

In designing a practical system of managed competition, two questions are pivotal:

- First, can rates for health care plans be set so that insurers are not rewarded for "cream-skimming"?

  Under current arrangements, a company offering health insurance makes more money by attracting people who are healthier than average and by not insuring bad health risks. Whether a system of managed competition could prevent cream-skimming—which would undermine the system—is much debated. Our work on Medicare's rate-setting for HMOs illustrates the difficulty of the task.

- Second, would managed competition achieve cost savings at the expense of quality?

To prevent this, the proponents of managed competition stress the need to create new sources of information about the quality of health care. How quickly such information could be generated and how consumers would use it are, however, open questions. Our work on HMOs for Medicare enrollees shows that quality assurance is needed to avoid abuses due to cost-cutting.

The strategy of managed competition is appealing to many. The Netherlands, for example, is in the early stages of implementing a particular version of the strategy. But evaluating the likely effectiveness of managed competition is hampered by lack of a real test, abroad or within an American state, in which a system of managed competition could be observed. Some research on states with relatively strong competition among HMOs and other managed care providers is mildly encouraging. Nonetheless, these states have not implemented managed competition, so it is difficult to draw conclusions from them about how much a managed competition system would flatten the trend in costs.

The alternative approach, direct controls, uses fee schedules and other price controls, spending targets and caps (sometimes called "global budgets"), and controls on the dispersal of new technology. Our analysis of these controls also reveals both strengths and weaknesses.

Direct controls have been employed in many different settings and have been implemented in a variety of ways. For example, direct controls are used systemwide in countries with many insurers (such as Germany) and with a single insurer (Canada). In the United States, direct controls are used at the federal level (Medicare uses a fee schedule and has introduced a spending target for physicians' services), at the state level (Maryland sets hospital rates), and at the local level (Rochester, New York, has used global budgets for hospitals).

In addition, direct controls have, with different degrees of success, restrained health care costs. Our studies of American and foreign health care provide evidence on the effectiveness, in particular, of spending controls and price controls. Thus, we found that the cost containment strategy used in Rochester, New York—which included global budgets—seemed to have slowed the rise in hospital costs. For France and

Germany, our analysis showed that targets and caps slowed the rate of spending increases compared with what would have happened without these policies. Our analysis also confirmed that the strength of enforcement is important: In Germany, spending caps have replaced targets, which were more weakly enforced, and the caps have proved more effective in limiting spending.

Direct controls on prices also have been relatively effective in containing costs. As our analysis showed, U.S. states that have set rates for hospital services to which all insurers in the state must adhere have slowed the growth in their per capita health spending. In addition, Medicare, which uses a variant of price controls in reimbursing hospitals, has slowed the rise in its costs for hospital services. Other countries' experience with price controls is generally consistent with these findings for the United States.

Direct controls are not a panacea, however. Even viewed just in terms of cost containment, they do not eliminate all spending pressures. Moreover, direct controls can hamper efficiency and retard innovation. Budgeting procedures may not reward efficient providers and insurers and may not penalize inefficient ones. Spending caps and targets may freeze the prevailing system of delivering health care and discourage innovations like managed care. Budgets may adapt too slowly to changes in technology, the demographic mix of patients, and methods of delivering care. Price controls can slow or block a needed shift of resources, say from one specialty to another, when demand or supply conditions change. To some extent these difficulties can be mitigated, but still they must be weighed when the choice of a spending control strategy is made.

In sum, neither managed competition nor direct controls is without drawbacks. Indeed, some analysts and policymakers are crafting proposals that combine the market-oriented advantages of managed competition with the extra cost discipline of direct controls—specifically, a cap on overall health spending. These hybrid plans are too sketchy as yet for observers to determine whether the two strategies can be blended, or how effective such a hybrid system might be.

# Administrative Simplification

In the United States, nearly 6 percent of total health expenditures in 1989 were accounted for by the administration of government health programs and private insurers. In sharp contrast, Canada spends about one-fifth as much proportionately on these insurance overhead functions. In addition, U.S. providers spend billions of dollars each year for billing and other administrative activities directly attributable to our system of financing health care. Providers in Canada, Germany, France, and Japan incur lower costs, in part because they deal with a more unified payment mechanism. While considerable debate continues about the precise magnitude of the potential savings in administrative overhead and providers' administrative burdens associated with specific reform proposals, there is general agreement that significant savings can be achieved in this area.

Administrative expenses for private insurance plans average about 12 percent, but they can be as high as 40 percent of claims costs for individual and small group plans. When multiple insurers market a range of plans differing in scope of coverage, the result is significant overhead costs to cover claims processing and marketing. While a wide range of insurers and plans may create greater consumer choice and greater responsiveness to consumers' needs, this wide range is part of the reason for higher administrative costs. Physicians, hospitals, and other providers must expend resources on billing and administrative procedures to deal with the fragmented payment system.

Almost all reform proposals attempt to achieve cost savings by reducing administrative costs through one or more of the following approaches:

- combining large numbers of employers into large insurance-buying cooperatives to achieve administrative economies,
- defining a single or limited number of basic insurance plans to reduce marketing costs and the burden on providers,
- developing standardized claims forms and billing procedures for all insurance plans and providers,
- eliminating insurance underwriting activities,
- eliminating deductibles and copayments to eliminate the need for providers to issue bills,
- using more inclusive methods for reimbursing providers, such as global budgets, and
- using a single payer with uniform payment rules and procedures in each market area.

Canada, for example, achieves substantial administrative savings through a combination of a single payer with uniform payment rules and elimination of all deductibles and copayments. The United States might achieve a similar level of administrative savings if it adopted a Canadian-type reform, but the savings could be largely offset by the additional use of services associated with the elimination of deductibles and copayments. Alternatively, the United States could retain deductibles, copayments, and utilization review activities. This approach would reduce potential administrative savings but result in greater control over potential costs associated with increased use of health services. If the United States should choose a system that depends on employer-based private insurance, some level of administrative savings could still be achieved through a combination of the other approaches described above.

## Fraud and Abuse Controls

The United States may want to invest more, rather than less, in the administrative resources required for detection of fraudulent and abusive practices by health care providers. Estimates vary widely on the losses resulting from fraud and abuse, but the most common is about 10 percent of total health care spending or about $80 billion annually. Only a token amount of administrative resources are devoted to detection and elimination of fraudulent and abusive practices.

Both public and private health insurance programs are subject to fraud and abuse but separately appear unable to combat it successfully. Our work suggests that fraud and abuse may be even more prevalent in privately insured programs, in which control efforts have not been as prominent and data systems are more fragmented. Indeed, federal health care programs have taken the leadership role in prevention of such practices. While a simpler and more uniform payment and administrative system may make it easier to detect potential fraud and abuse, we believe that investing the needed resources in designing the administrative structure and continuing surveillance to limit the potential for such practices is essential. These issues are discussed more fully in our related report, Medicare Claims (GAO/HR-93-4, Dec. 1992).

# Diffusion and Pricing of New Medical Technologies

The rapid spread and increased use of new medical technologies has been relatively unrestrained in recent years and has given health spending added momentum. Technological advances have sometimes led hospitals to participate in a medical "arms race," as they acquire expensive technology and seek to keep patients and doctors from shifting to rival hospitals.

Once declared eligible for reimbursement, third-party payers—business, government, and private insurers—have primarily shouldered the financial burden of these technological advances. However, insurers' payment policies have not always encouraged efficient and prudent use of these medical services. Instead, insurers have left themselves vulnerable to excessive spending by giving providers incentives to be wasteful or abusive in offering medical services. In particular, our work has shown that in some cases, insurers have not adjusted payment rates to reflect the effect of maturing technology on costs.

The challenge for policymakers is to find ways to encourage development of new technologies while ensuring their efficient use. This can be accomplished through payment policies that reflect the costs incurred by high-volume, efficient providers.

# Medical Malpractice Reform

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Savings in addition to those stemming from comprehensive health care reform can be achieved through fundamental changes in the U.S. medical malpractice system. The United States faces higher costs for medical malpractice insurance and associated defensive medicine costs than other nations.

U.S. medical malpractice premiums are estimated to be only about 1 percent of total U.S. health care costs. There is considerably wider variation in estimates of the potential additional costs of defensive medicine—diagnostic tests and procedures performed solely to protect physicians in the event a malpractice claim is filed. The American Medical Association estimated the costs of defensive medicine at $20 billion in 1991. Moreover, physicians want relief, not only from the financial burdens of malpractice, but also from its emotional burdens.

Cost reduction should not be the sole basis for malpractice reform. Malpractice reform also should be directed toward providing better access to compensation for those who are injured. Arbitration and no-fault programs have been implemented in various states as an alternative to a complex and expensive court process. Many of these programs also incorporate local practice guidelines that, although not an absolute defense, provide evidence in a judicial process that accepted medical protocols were followed. Furthermore, hospitals and other medical settings are adopting risk-management programs that are expected to improve the quality of care. We believe these efforts should continue to be studied and, when positive effects are demonstrated, should be considered in conjunction with comprehensive health care reform.

# Observations About Health Care Reform

Reform of U.S. financing of health insurance and payment of health care providers is a daunting task. U.S. health care is an $800 billion enterprise that is diverse, complicated, and dynamic. Achieving reform will be particularly difficult because, to many people, reform seems to threaten a good situation. People whose health insurance is adequate and whose health care is good may fear that reform will result in diminished care or higher costs for them. For providers as well as consumers, reform of the health care marketplace will cause a considerable reshuffling and generate losers as well as winners.

Moreover, reform will not produce a structure that is perfect. Our reviews of the health systems of other countries shows that after putting major reforms in place, these countries continue to seek ways to improve their systems. We believe that the imperfections of any reform—and the dynamic character of the health care industry—make a stream of further changes inevitable in the years ahead. However, there may be greater risks in not undertaking comprehensive health care reform. Without reform, costs will continue to escalate while a substantial number of Americans lack access to health insurance.

# Related GAO Products

### Alternative Health Care Systems

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (GAO/HRD-93-44, forthcoming).

Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Health Care Spending Control: The Experience of France, Germany, and Japan (GAO/HRD-92-9, Nov. 15, 1991).

Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991).

### Health Care Costs

Hospital Costs: Adoption of Technologies Drives Cost Growth (GAO/HRD-92-120, Sept. 9, 1992).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (GAO/HRD-92-36, Feb. 13, 1992).

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 10, 1991).

**Health Insurance**

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

**Fraud and Abuse**

Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28,1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

**Medical Malpractice**

Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992).

Reprinted from Chapter 4: The Economics of Health Care, Economic Report of the President [Bush]], transmitted to Congress, Jan. 1993. p. 119-168.

## CHAPTER 4

# The Economics Of Health Care

AMERICANS ARE LIVING LONGER, healthier lives than ever before. Since 1960, average life expectancy has increased by more than 5 years. American physicians have access to the best technology in the world and more than one-half of the world's medical research is funded by private and public sources in the United States. At the same time, the share of the Nation's income devoted to health care has been growing rapidly, and today more than 35 million Americans lack health insurance. Growing concern about rising expenditures and reduced access to insurance has led to the development of a wide variety of proposals for health care reform, from the Administration's market-based approach to calls for a government-run national health insurance program.

The success of any of these proposals will depend on how well it addresses the reasons behind the increase in expenditures and decline in insurance. Economics is very helpful in understanding these developments. It suggests that most health care in the United States is financed and delivered in ways that give both health care providers and their insured patients many incentives to increase the quality of health care but little reason to be concerned about its cost.

## HEALTH CARE IN THE UNITED STATES

In many respects, the health care industry resembles other service industries such as transportation and legal services. It supplies a service—health care—in response to consumer demand. But the demand for health care is different from the demand for many other services because most people do not pay for their care directly. Instead, the government and private insurers pay most health care expenses. The supply of health care also differs from that of many other service industries. Consumers rely on providers for information about health care services and these providers are heavily regulated, primarily by other health care providers. Finally, many people believe that health care is inherently different from other goods and services. They believe that everyone should be entitled to at least some health care, although they may not believe that everyone has a similar entitlement to goods in general.

## THE HEALTH OF THE U.S. POPULATION

Americans buy health care to improve their health, but recent research suggests that the connection between health care and health is not a simple one. In fact, increases in life expectancy in developed countries are not strongly related to increases in the number of physicians or hospital beds per capita, nor are they primarily a consequence of increasing utilization of these services. *Studies show that increases in life expectancy are mainly related to changes in behavior and improvements in medical technology.* Between 1960 and 1990, life expectancy at birth, which is strongly affected by changes in infant mortality, rose from 67 years to 72 years for men and from 73 years to 79 years for women. The life expectancy of older Americans, a group that may be more strongly affected by improvements in medical technology, increased by 3 years between 1960 and 1990, a larger increase than occurred between 1900 and 1960.

### *Changes in Behavior*

Changes in behavior offer great promise as a way to prevent disease and preventing disease is often less costly than treating it. Many Americans have adopted increasingly healthy lifestyles. During the 1980s, the rate of smoking among adults decreased from 33 to 26 percent, more Americans exercised regularly, and deaths associated with alcohol abuse declined substantially. Traffic accident deaths per capita have declined by over 30 percent since 1970, in part because of greater use of seat belts.

### *Medical Technology*

Improvements in medical technology (a term that includes drugs, vaccines, and knowledge about treatments as well as medical equipment) reduce the incidence of disease and improve the effectiveness of treatment. For example, over 33,000 cases of polio were reported in the United States in 1950, but polio has been all but eradicated since the development of the polio vaccine. Only 25 years ago, childhood leukemia was nearly always fatal; today the long-term survival rate for children diagnosed with leukemia is about 65 percent. New drugs have greatly improved the well-being of those with ulcers and virtually eliminated the need for surgery to treat this medical problem. Similarly, coronary bypass surgery has greatly improved the quality of life of those with angina.

### *Continuing Problems*

Despite the many medical advances of recent years, cures for many diseases have yet to be discovered and new diseases continue to emerge. For example, the rate of mortality from breast cancer has not improved since 1950 despite the development of new screening methods and new treatment therapies. Acquired immune deficiency syndrome, or AIDS, has claimed the lives of over 160,000 Americans. Tuberculosis, a disease that had almost disappeared in the United States, has reemerged. Among young people, homicide and drug abuse exact an enormous toll.

A further problem is the persistence of serious disparities in health across income and race categories. For example, black babies are more than twice as likely as white babies to have low birthweight. While many ascribe these differences in health to differences in the ability to pay for care, evidence from the United States and other countries casts doubt on the belief that health insurance alone can greatly narrow these disparities. Studies in the United Kingdom have found that the gap in mortality between rich and poor has actually increased since the introduction of national health insurance. This result is consistent with evidence showing that increased utilization of medical services has relatively little effect on health.

## PROVIDING AND PAYING FOR HEALTH CARE SERVICES IN THE UNITED STATES

The U.S. health care industry as defined in government statistics includes services provided in hospitals, nursing homes, laboratories, and physicians' and dentists' offices. It also includes prescription and nonprescription drugs, artificial limbs, and eyeglasses, as well as the services of nontraditional practitioners. But many goods and services that may strongly affect health, such as fitness club services and food, are not included in the usual definition.

The U.S. health care industry employs 9 million people, including over 600,000 physicians; by comparison, the automobile manufacturing industry employs about 800,000 people. Inpatient services are provided by approximately 6,500 hospitals containing over 1 million hospital beds. One-half of these hospitals are private, nonprofit institutions, some 30 percent are operated by Federal, State, and municipal governments, and the remainder are operated privately on a for-profit basis.

Health care expenditures averaged $2,566 per person in 1990 and were divided among health care services in almost the same proportion as in 1960. The largest part of each health care dollar, about 38 cents in 1990, was spent on hospital care, which covers all services billed through a hospital, including those of some physicians, such as medical residents and radiologists. More than 1 in every 10 Americans was admitted to a non-Federal short-stay hospital (a hospital in which the average length of stay is less than 30 days) in 1990, for an average stay of 6 days; over 10 percent of these admissions were for maternity care. Physician services are the second largest category of expenditures, accounting for about 19 percent of health care expenditures. In 1990, the average

American made 5.5 visits to a doctor. Most of the remaining 43 percent of health care expenditures was divided among drugs, nursing home care, dental services, vision products, and home health care services.

In most other developed countries, the government plays a larger part in financing and, in many cases, in delivering health care than in the United States. Boxes 4-1, 4-2, and 4-3 describe the health care systems in Canada, Germany, and the United Kingdom.

**Box 4-1.—Canada**

Since 1971, all Canadians have been covered by public health insurance plans administered by the Provinces. In Canada, it is illegal to sell private insurance for services provided by the public plans and participating physicians and hospitals may not accept direct payment from patients for those services. While the Provinces differ in the methods they use to finance health care, most funding comes from general tax revenues.

Physicians are paid by the provincial governments on a fee-for-service basis according to a fee schedule negotiated by the provincial governments and physician associations. There have been very substantial increases in the utilization of physician services since the introduction of public health insurance. Attempts to cut total costs by limiting physicians' fees have been partially thwarted by these continuing increases in utilization.

Hospitals receive annual lump sum, or global, budgets that are not tied directly to hospital expenditures. Hospitals cannot purchase new equipment without government approval and many types of high-technology equipment are less common in Canadian than in U.S. hospitals. The global budget reimbursement system and restrictions on the purchase of equipment have led to waiting lists for some nonemergency hospital services.

### *Financing Health Care*

Since 1960, U.S. health care financing has undergone a major change (Chart 4-1). In 1960, most medical care was paid for directly by consumers, but by 1990 only 23 percent of health care expenses were paid for directly by consumers. Thirty-two percent were covered by private health insurers and 41 percent by the government. This change can be traced to three developments: the expansion of employer-provided benefits, the development of medicare (a government program that finances care for the elderly and disabled), and the initiation of medicaid, a program that extended and formalized

**Box 4-2.—Germany**

All working Germans and their families are required to have health insurance. Those with low and middle incomes must participate in one of the approximately 1,100 not-for-profit health insurance plans known as sickness funds. Most blue-collar workers are assigned to a specific plan, while most white-collar workers may choose among plans. In addition, about 26 percent of the population earn incomes high enough to allow them to opt out of the sickness funds and purchase private insurance; over one-third of those eligible do so. Out-of-pocket payments in the sickness funds are very low. The sickness funds are financed primarily from payroll taxes, and premium rates can vary substantially according to the fund. General revenues are used to fund coverage for the nonworking poor, who are insured through the sickness funds.

German physicians belong to regional associations that negotiate lump-sum budgets with the sickness funds. Individual physicians are then reimbursed by the physicians' associations on a fee-for-service basis, with the fees adjusted retroactively to comply with the negotiated budget. Hospitals are paid operating costs negotiated between the hospitals and sickness funds and pay the salaries of their staff physicians out of these operating costs. Hospital capital investments are mainly paid for by State governments.

Germans make many more physician visits per year than Americans, but the average visit is much briefer. Germans also spend more days in the hospital, on average, than do Americans. The ratio of hospital staff to patients, however, is much lower in Germany than in the United States, and Germany does not have as much high-technology equipment. Physicians spend, on average, more time with privately insured patients than with those enrolled in the sickness funds, and hospitals provide special facilities for these patients.

existing programs to finance health care for the poor. *People no longer bear most of the financial responsibility for their own health care decisions; instead most Americans have relatively little exposure to the cost implications of these decisions.*

## EMPLOYER-PROVIDED BENEFITS

Large numbers of American employers first began offering health insurance benefits to their employees during World War II. During and after the war, Federal wage and price controls led businesses to expand nonwage benefits such as health care—which

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**Box 4-3.—United Kingdom**

In the United Kingdom, the National Health Service (NHS) finances and delivers health care. All residents are eligible to receive care through the NHS, although a small but growing private insurance market also exists. The NHS is financed primarily from general revenues and only very low copayments are required for a limited number of goods and services.

Almost all physicians are employed by the government, which also owns most of the hospitals. Office-based primary care physicians who are part of the NHS are compensated in part through payments for each patient, adjusted according to the patient's age. Specialists are salaried and may only see those patients who have been referred by a general practitioner.

Expenditures per person are much lower in the United Kingdom than in other developed countries. Health care in the United Kingdom is characterized by a much lower level of high technology and fewer physicians per capita than in Canada, Germany, or the United States. There are long waiting lines for many high-cost, nonemergency procedures, and physician visits are very short.

were exempt from the controls—in order to attract workers. By 1960, private employers were paying for about 13 percent of national health care expenditures, and today, most Americans receive health insurance benefits through their employers (Chart 4-2).

### *Tax Treatment of Benefits*

Tax provisions that exempt employer-provided health insurance from Federal and State income taxes encourage the spread of such insurance. Employees do not pay tax on the share of their compensation that comes to them in the form of employer-paid health insurance. This preferential tax treatment is effectively a government subsidy. The amount of the subsidy depends on the worker's tax rate: the higher the tax rate, the greater the subsidy. The greater the subsidy, the more likely workers are to want a larger part of their compensation in the form of health insurance.

Firms can increase the generosity of a health insurance package by lowering deductibles (the fixed amounts that policyholders must pay toward bills each year before any insurance payments are made), copayment rates (the share of medical bills that must be paid by policyholders), or the employee's share of premiums. Employers may also expand the range of services included in policies, as they did during the 1980s, when an increasing proportion began to offer vision and home health care benefits. Between 1972 and

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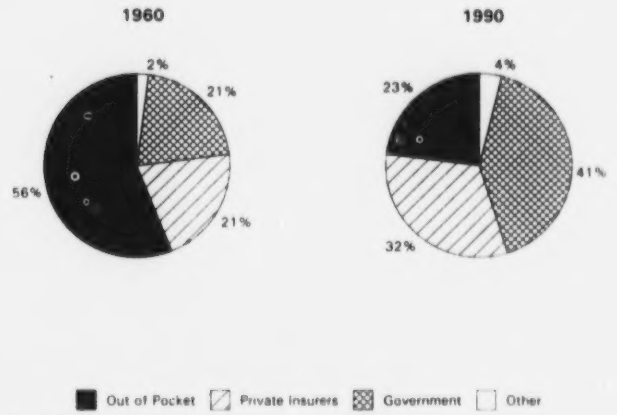
Chart 4-1 **Paying for Health Care Expenditures: 1960 and 1990**
The share of health expenditures paid for out of pocket has fallen substantially since 1960.

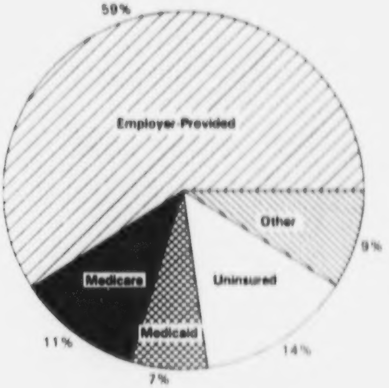


Source: Health Care Financing Administration.

1989 the total cost of all deductibles, copayments, and employee-paid insurance premiums remained almost constant as a share of after-tax income, at about 5 percent, despite the sharp increase in overall health care expenditures.

As tax rates have changed over time, so has the proportion of health care expenditures funded by employer payments. In 1965, when the marginal combined Federal tax rate of the median worker (including the Federal income tax and the employee's and employer's shares of the Social Security and medicare tax), was 17 percent, private employer contributions for private health insurance accounted for 14 percent of U.S. national health care expenditures. By 1982, when the combined marginal rate reached 38 percent, 21 percent of U.S. health expenditures were accounted for by private employer contributions for private insurance. During the 1980s, the marginal combined tax rate of the median worker fell (to 30 percent in 1990) and the share of national health care expenditures paid for by private employer contributions stopped rising, remaining at about its 1982 level, although the dollar amount of employer health care expenditures continued to increase.

**Chart 4-2 Health Insurance Coverage**
Most Americans receive health insurance through their employers.



Note: Other includes, for example, privately purchased health insurance and the Department of Veterans Affairs.
Sources: Department of Commerce and Congressional Research Service.

Employer-sponsored insurance is also exempt from State income taxes in most States, but these taxes are not included in the above figures. State income taxes currently range between 0 and 12 percent, so that for most people the entire tax subsidy is greater than the Federal subsidy.

By not taxing benefits as income, the government is effectively forgoing revenues that could be used to lower tax rates. If all the health insurance benefits expected to be provided in 1993 were counted as part of Americans' taxable income, the Federal Government would collect approximately $65 billion in additional revenues.

### *Insurance Costs and Money Wages*

A firm's cost of health insurance must be passed along to someone—customers, owners, employees, suppliers, or some combination of these groups. *In most cases, employers are constrained in their ability to pass along these costs to their customers, owners, and suppliers. In general, when health insurance costs rise, firms must raise the cash component of wages less than they otherwise would in order to meet the higher health insurance costs.*

Between 1973 and 1989, employers' contributions to health insurance absorbed more than one-half of workers' real gains in compensation. Much of the growth in compensation reported for the 1980s took the form of higher health insurance premiums.

## THE GOVERNMENT'S ROLE

Until the mid-1960s, the government's role in the provision and financing of health care was limited primarily to prevention and medical research. Some government health care spending continues to be targeted to these areas. The Federal Government spent over $22 billion in 1992 on preventive health efforts, including $594 million spent for AIDS prevention and $297 million for childhood immunizations. In 1990 the Federal Government spent about $10 billion to fund medical research. Since the mid-1960s, the government has also taken an active role in providing health insurance.

### *Medicare*

Medicare, a nationwide Federal health insurance program that began in 1966 for people over 65 and for those with disabilities, is comprised of a hospital insurance program and a supplementary medical insurance program. Most Americans over the age of 65 are eligible for medicare hospital insurance benefits, which they receive without paying a special premium. Some disabled persons under 65 and most people who suffer from chronic kidney disease are eligible for medicare hospital benefits.

Medicare hospital benefits cover all reasonable costs for 60 days of inpatient hospital care per year, after a $676 deductible; days 61 through 90 are covered with a daily copayment of $169. In addition, those insured through medicare have a 60-day lifetime reserve for hospitalizations exceeding 90 days, during which they must contribute $338 a day toward the cost of their care. (These deductible and patient payment amounts are for calendar year 1993.) Medicare hospital insurance also provides limited coverage for posthospital nursing services, home health care, and hospice care for the terminally ill.

Participation in the medical insurance portion of medicare is voluntary. For a monthly premium of $36.60, people 65 and over and all others eligible for hospital benefits may purchase medical insurance. When the medicare program began, premium income financed half the cost of supplementary medical insurance but today premiums cover only about one-quarter of the costs of these benefits and general tax revenues cover the remainder. Medicare medical insurance covers physician services, laboratory and other diagnostic tests, and outpatient hospital services. It generally pays 80 percent of the approved amount for each service with an annual deductible of $100.

Many medicare beneficiaries purchase additional private insurance, called medigap insurance, to cover deductibles and copayments that are not paid by medicare. In 1990, 77 percent of medicare beneficiaries had medigap insurance. Of these, some 44 percent purchased such insurance directly; another 40 percent were retirees receiving medigap coverage through their former employers. For medicare recipients below the poverty level, another government program, medicaid (discussed below), provides this additional coverage. A recent change in Federal law requires that all medigap insurance must cover all patient payments for hospital and medical care except the deductibles. Purchasers of medigap insurance have relatively few out-of-pocket expenses for hospital and physician bills. New medicare beneficiaries (those who have just turned 65) are guaranteed the right to purchase medigap insurance at the same rate regardless of their health status.

### *Medicaid*

Medicaid is a Federal-State matching entitlement program that provides medical benefits to low-income individuals including the elderly, blind, disabled, children, adults with dependent children, and some pregnant women. Eligibility for medicaid has been tied to participation in the aid to families with dependent children (AFDC) or supplemental security income program. In 1986, the Congress extended medicaid coverage to pregnant women and children under 6 whose family incomes fall below 133 percent of the Federal poverty level. States may choose to cover all pregnant women and all children under the age of 1 with family incomes of up to 185 percent of the Federal poverty level, and 29 States currently do so. By 2002, the medicaid program will be required to provide coverage for all children under 18 whose families are below the Federal poverty line.

For some senior citizens whose incomes are below the poverty line and who receive medicare benefits, medicaid pays deductibles and copayments for physician and hospital expenses. Medicaid also covers long-term nursing home care: some 25 percent of all medicaid expenses in 1987 were for nursing home care for those over 65.

Each State administers its own medicaid program according to Federal eligibility guidelines. The Federal Government contributes 50 percent of the State's administrative costs and a percentage of the medical expenses based on a matching formula that gives more money to poor than to wealthy States. The Federal share of medicaid costs ranges from a low of 50 percent to a high of 79 percent. Federal law mandates that medicaid beneficiaries can be required to pay only small copayments.

In 1990, 25.3 million persons received medicaid benefits. *Expenditures for the aged, blind, and disabled, who account for only 27 per-*

*cent of the caseload, made up about 70 percent of the outlays. Dependent children accounted for only 14 percent of medicaid outlays.*

## RECENT CHANGES IN THE PROVISION OF CARE

Until the late 1970s, most providers of health care in the United States were paid using a system called retrospective reimbursement that paid for each service provided, encouraging providers to increase their services. Hospitals and physicians had incentives to counsel patients to accept more and costlier treatments, and insured patients had little reason to question these recommendations because services were paid for largely by insurance. Physicians and hospitals competed for patients by improving the quality of their services, driving up prices.

During the 1980s, some attempts were made to control expenditures by encouraging physicians and hospitals to compete in ways that keep costs down. Competition among insurers led to an increase in the use of innovative payment methods that, in turn, have begun to create an environment in which competition among providers may lead to lower health care costs.

### *Institutional Responses: Capitation and Coordinated Care*

Under retrospective reimbursement, insurers paid physicians and hospitals for the costs of services after the fact. There were few restrictions on payments, and providers had little reason to compare the costs and benefits of services for insured patients. Insurers using the retrospective reimbursement system responded to rapidly rising expenditures by reviewing physician behavior more closely. This oversight has taken different forms, including increased monitoring, or case management, for more costly cases (a procedure used by an estimated 67 percent of employers in 1991) and requirements that patients seek a second opinion before undergoing surgery (used by about 49 percent of employers in 1991).

As health care expenditures rose during the 1970s and 1980s, however, insurers also experimented with alternative reimbursement strategies that would create incentives to control expenditures while ensuring quality care. One major innovation was the expansion of coordinated care programs that use capitation-based reimbursement and direct review of the utilization of medical and hospital services (Box 4–4).

Under capitation-based reimbursement, physicians receive an annual payment for each patient in their care, regardless of the services a patient uses during the year. Coordinated care organizations, which include health maintenance organizations (HMOs) and preferred provider organizations, often use the capitation system to pay providers. By 1990, 33 million Americans were receiving care through HMOs, over 5 times as many as had 15 years earlier.

### Box 4-4.—Coordinated Care

The term "coordinated care" describes a variety of arrangements that increase coordination and management of health care services. The best-known form of coordinated care is the HMO, which provides its services through a single group of doctors and other health care providers. Individuals enrolled in an HMO pay a specific annual fee, regardless of the services they receive, although a small copayment is sometimes charged for services.

Another popular form of coordinated care is the preferred provider organization, which contracts with a group of providers who are reimbursed for services based on a negotiated fee schedule. Preferred provider organizations usually incorporate programs to monitor the use of services to ensure that physicians do not offset lower fees with increased volume.

Coordinated care programs have been shown to reduce expenditures while maintaining the quality of care. Some studies have found that coordinated care programs reduced the cost of care by as much as 30 percent.

Although coordinated care has become increasingly common in the private sector, it has not been as popular in public insurance programs. Medicare began entering into contracts with HMOs in the mid-1980s. Because medicare beneficiaries have few incentives to join HMOs, however, very few have done so. Congressional restrictions on the use of coordinated care by State medicaid programs have impeded the growth of such arrangements for medicaid recipients and fewer than 10 percent of medicaid beneficiaries currently receive care through these arrangements.

These innovations, which have occurred largely in the private insurance market, have reduced health care expenditures while offering health care that is at least as good as that of traditional retrospectively reimbursed medicine. In fact, capitation-based payment gives physicians a financial incentive to invest in preventive care, because they benefit financially when their patients remain healthy. *Studies show that costs have risen more slowly in health care markets where there is vigorous competition among many coordinated care providers.*

### *Diagnosis-Related Groups*

In an effort to control rising hospital expenses, which make up the bulk of medicare payments, the Federal Government in 1983 replaced the existing retrospective payment system with a prospec-

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tive payment system. The new system reimburses hospitals with a fixed amount for each patient based on the patient's diagnosis, rather than on the services provided. A medicare patient admitted to a hospital is now classified as belonging to one of 470 diagnosis-related groups (DRGs) that form the basis for payment.

In principle, hospitals could compete to offer care for a particular DRG at the lowest price. The medicare program, however, has set fees for each DRG, limiting the opportunities for price competition among hospitals. Payment for each DRG is based on the average cost of treatment but may vary according to region and type of hospital. Hospitals that can provide care at less than the average cost profit from this system.

Hospitals have responded to the new incentives the DRG system provides. The length of the average hospital stay has fallen significantly. A study that compared hospital costs under DRGs with estimates of what costs would have been without DRGs suggests that the system led to a one-time decline of about 20 percent of the cost of hospital care paid for by medicare. The DRG system may also slow increases in expenditures by removing the incentive that operated under retrospective reimbursement to add costly services. Finally, a substantial amount of evidence suggests that the DRG system has not reduced the quality of care medicare patients receive, even though it provides hospitals with an incentive to limit the services provided to a patient with a particular diagnosis.

### *The Resource-Based Relative Value Scale for Paying Physicians*

In response to the increases in physician expenditures during the 1980s, the medicare program in 1992 began implementing a new fee system for physicians. The old system had reimbursed physicians the customary fee, a practice that could lead to cost spirals. If one physician raised fees, the average would rise, and this increase could be included in the next fee schedule.

With the new resource-based relative value scale, the Federal Government sets the fee medicare pays for each service according to the complexity and duration of the treatment. The current scale has greatly increased the reimbursement for evaluative functions and reduced the reimbursement for surgery.

Unfortunately, the method used to determine the new fee schedule may not be sound. Theoretically, fees should reflect not only time and effort but also demand for the service and the willingness of physicians to perform it. Unless a fee schedule takes into account these fundamental economic forces, it is likely to lead to shortages and surpluses in particular specialties, especially those with changing technology.

## SUMMARY

- Improvements in technology and behavioral changes have led to significant improvements in Americans' overall health. Americans are living longer, healthier lives, free from many life-threatening illnesses. Many serious problems have developed, however, including AIDS and a recurrence of tuberculosis.
- The government's share of total health expenditures has increased and the share of patient out-of-pocket spending in total health expenses has been falling. People have much less responsibility for the financial consequences of their health care decisions than they did thirty years ago.
- Most Americans are insured through their employers. Employer-provided insurance benefits have increased dramatically since World War II, in part because such benefits are excluded from employees' taxable income. Employees pay for increases in health care costs mainly through lower wages. Individual expenditures for deductibles, copayments, and insurance premiums remained roughly constant as a share of after-tax income between 1972 and 1989.
- Insurers have responded to cost increases with innovative changes in the financing of care, moving away from fee-for-service, retrospective reimbursement of independent providers to prospective, capitation-based reimbursement of networks of providers.

## RISING EXPENDITURES, DECLINING INSURANCE COVERAGE

The impetus for health care reform is driven by two concerns: the rapid rise in health care expenditures and the increasing percentage of Americans who lack health insurance.

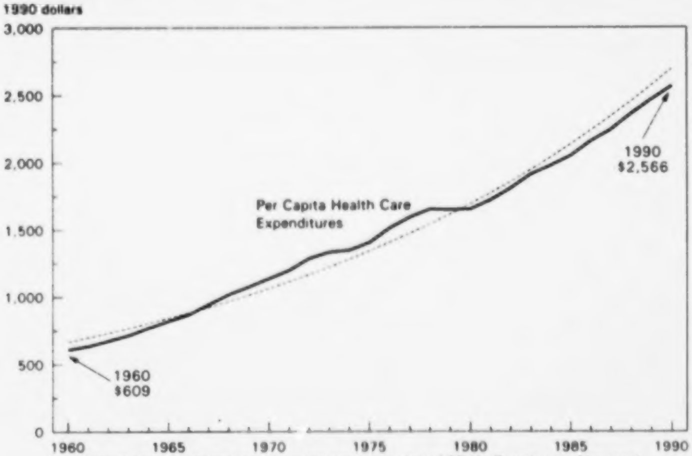
### TRENDS IN HEALTH CARE EXPENDITURES

Chart 4-3 shows the change in spending on health care since 1960. Some increases were due to the expansion of health insurance benefits through the establishment of the medicaid and medicare programs in the mid-1960s. Health care spending has continued to escalate since then.

Studies that examine patterns of health care spending across countries show that the share of income countries devote to health care usually rises with national income. Health expenditures in the United States are no exception. Expenditures rose more quickly than incomes between 1960 and 1990, from 5 percent of gross national product (GNP) in 1960 to 12 percent.

**Chart 4-3 Real Per Capita Health Care Expenditures**

**Real per capita health care expenditures have been rising at an average annual rate of 4.6 percent since 1960.**



Note: Expenditures are deflated by nonmedical care component of CPI U. Growth rate of log trend is 4.6 percent per year.

Sources: Department of Labor and Organization for Economic Cooperation and Development.

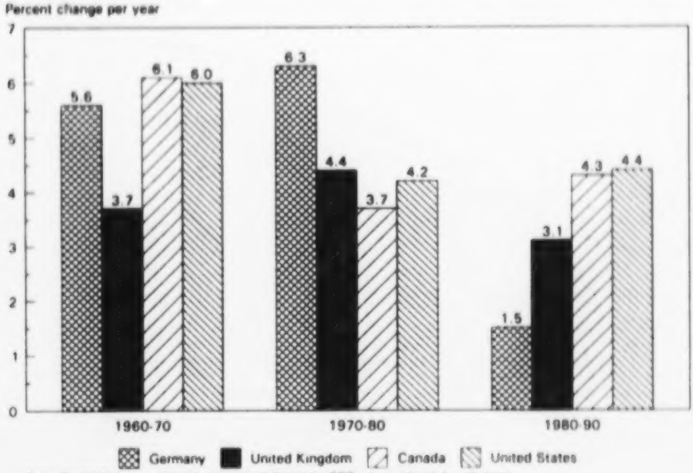
Health expenditures are not greatly affected by short-term changes in economic conditions. *Health care costs often continue to grow during economic downturns, so that the share of national income devoted to health care may rise during a recession and fall when prosperity returns.*

## HEALTH CARE EXPENDITURES IN OTHER DEVELOPED COUNTRIES

America is not alone: Germany, the United Kingdom, Canada, and other industrialized countries all experienced large increases in health care spending between 1960 and 1990. As Chart 4–4 shows, spending in Germany increased rapidly between 1960 and 1980, but slowed sharply in the 1980s. In Canada, the United Kingdom, and the United States, expenditures increased rapidly in all three decades. Although outlays for health care have increased substantially in all four countries, per capita health care spending in the United States has historically been considerably higher than in the other three countries. The United States currently spends about 1.5 times as much on per capita health care as Canada, about 1.7 times as much as Germany, and about 2.6 times as much as the United Kingdom.

**Chart 4-4 Growth in Real Per Capita Health Care Expenditures in Selected Countries**

Other countries have also experienced substantial increases in health care expenditures since 1960.



Note: Expenditure in national currency deflated by GDP price indexes for all items.
Source: Organization for Economic Cooperation and Development.

The rapid growth in health care spending in the United States, Canada, Germany, and the United Kingdom is somewhat surprising because these countries have very different systems of health care financing and provision. As health care expenditures continue to increase, each of these countries is considering health care reform. *In some cases, these reform proposals include incorporating features of U.S. health care financing and provision. The United Kingdom and Canada have been experimenting with coordinated care systems, the United Kingdom has been developing versions of DRGs, while Germany has been increasing the use of patient copayments.*

## THE UNINSURED

Besides rising costs, the other major problem in U.S. health care has been the increasing number of Americans who lack insurance—over 35 million people, according to current estimates. Because so many Americans receive health insurance through their employers, the percentage of Americans without health insurance is affected by changes in employment. The number of uninsured, however, increased during the 1980s, even during periods of economic growth.

### *Who Are the Uninsured?*

Although medicaid covers many of the very poor, about 47 percent of those with incomes below the poverty line, the probability of being uninsured is highest among those with low incomes. As incomes rise, so does the probability of having health insurance.

Those in the 18–35 age group are more likely to be uninsured than those of other ages. These young adults, most in good health, may have been covered previously by their parents' health insurance. Young adults who work are more likely than other workers not to accept health insurance coverage even when their employers offer it, and young adults who lose their jobs are the least likely to pay to retain their health insurance.

Most uninsured people report that their health is good or excellent relative to others of the same age. The population of uninsured Americans, however, also contains a group that is much sicker than average, with serious chronic health conditions. The chronically ill, who are very likely to incur high health care costs, may find it very costly to obtain insurance.

### *Other Problems with Insurance Coverage*

Health insurance is also a concern for people with limited insurance coverage and for those whose insurance ties them to a specific employer. Some people with insurance are susceptible to large out-of-pocket expenses, either as copayments or for services that their insurance does not cover. Estimates from the mid-1980s suggest that 7 percent of privately insured Americans under the age of 65 face a 1-percent chance of spending at least one-fifth of their family income on health care. Over 20 percent of those over 65 have not purchased supplementary medigap policies that cover medicare copayments and do not qualify for medicaid; they also may be subject to substantial financial burdens if they become seriously ill.

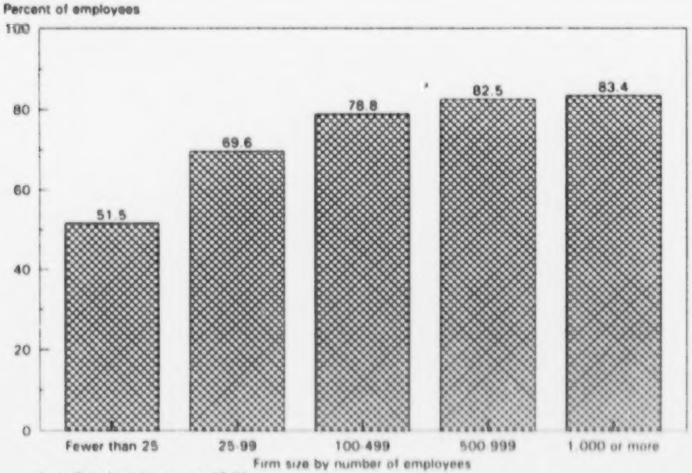
Those whose health insurance ties them to a specific employer face a different problem. Most private health insurance contracts contain preexisting condition clauses limiting or excluding coverage for conditions that began before the policy went into effect. These restrictions can force people with chronic conditions to stay with one job when they would prefer to move to another. Even those without chronic conditions may avoid changing jobs because they prefer to stay with one insurer. A recent survey found that over 25 percent of American households included a family member who stayed in a job because of health coverage.

### *Gaps in Employer-Provided Health Insurance Coverage*

Although not having a job greatly increases the probability that an individual is not insured, the majority of uninsured Americans

**are' workers or their dependents. Workers may lack health insurance because their firm does not offer it, because they do not work enough hours to qualify for benefits, or because they have been offered insurance and have chosen not to take it. While almost all large firms in the United States offer health insurance to their workers, small firms are far less likely to do so (Chart 4-5).**

Chart 4-5 **Employer-Provided Health Insurance, by Firm Size: 1990**
Employees of large firms are much more likely than employees of smaller firms to have health insurance.



Note: Data for persons aged 18-64.
Source: Employee Benefit Research Institute.

Three factors affect the ability and willingness of small firms to provide health insurance. First, the administrative costs of health insurance per employee rise rapidly as the size of a firm declines. Second, small firms are less able to self-insure their health insurance coverage—that is, pay expenses from their own funds rather than contracting with a commercial insurance company. About 65 percent of all firms self-insured the health costs of their employees rather than purchasing commercial insurance in 1991, but only 41 percent of firms with fewer than 500 employees self-insured their costs. Because small firms often purchase State-regulated commercial insurance, they incur costs associated with State-mandated benefits (for example, coverage for chiropractic services) and pay State insurance premium taxes. These mandates can be quite costly and may affect the probability that a small employer will offer insurance. Self-insured plans, on the other hand, are exempted from providing State-mandated benefits and paying State premium taxes under the Federal Employee Retirement Income Security Act (ERISA). Third, risk-spreading, which keeps costs down by pooling the cost of possible serious health problems among a large group is more difficult in smaller firms. When one employee of a small enterprise becomes seriously ill, the cost of premiums for the entire group increases much more than it would in a larger group.

This last observation is a matter of concern. The purpose of insurance should be to spread risk so that premiums do not increase in small groups when an employee becomes ill. To improve risk-spreading, small firms could purchase health insurance policies that remained in force for 5 or 10 years, rather than the 1-year contracts that are now customary. High employee turnover rates and high business failure rates in small firms, however, may make it costly for insurers and firms to make such contracts. Furthermore, continuing changes in medical technology may make it risky for insurance companies to offer long-term contracts.

Firms are considerably less likely to offer health insurance to their part-time employees than to their full-time employees, mainly because coverage for a part-time employee costs as much as it does for a full-time employee and accounts for a much higher share of part-time workers' total compensation.

## HOW THE UNINSURED USE HEALTH CARE SERVICES

Those who lack insurance do not necessarily forgo all health care. They may pay for care directly or may receive it for free, primarily through hospitals. In 1989, U.S. hospitals provided over $10 billion worth of free, or uncompensated, care. People without health insurance do use less health care than those with similar health problems who are insured, however.

People without health insurance are far more likely than those with insurance to report that they did not receive health care during an illness because of financial constraints. Those who do seek care are more likely to receive it in inappropriate and costly settings such as emergency rooms. The uninsured are likely to be sicker when they are admitted to a hospital; they are also likely to be discharged from the hospital earlier than their insured counterparts.

New estimates suggest that out-of-pocket health expenditures among the uninsured are lower than they are among insured people with similar incomes and are far less than the cost of purchasing a basic health insurance policy. Some uninsured people may be consciously choosing to rely on emergency room care and personal savings rather than purchasing costly health insurance coverage.

## RECENT CHANGES IN THE NUMBER OF UNINSURED

Many of the uninsured are unemployed. Although the Consolidated Omnibus Budget Reconciliation Act allows those who leave jobs to continue their coverage for up to 18 months through their employer's health care plan by paying the full cost of the premium, only about 20 percent of those eligible do so. Structural changes in the American labor market have also affected insurance coverage. Workers are most likely to be covered by health insurance if they are unionized or employed in the manufacturing sector. But employment in manufacturing fell from 23 percent to 18 percent of total employment during the 1980s, while the fraction of private sector workers represented by a union fell from 19 percent to 13 percent between 1983 and 1991.

These changes in the composition of the labor force, however, explain only a small percentage of the increase in the number of uninsured. As health insurance becomes more costly, more people may find it makes sense for them to seek higher wages rather than health insurance from their employers, relying instead on emergency care.

### *Low-Wage Jobs and Health Insurance*

For employers offering jobs at low wages, increases in the cost of health insurance make it especially difficult to offer coverage. These employers cannot lower wages to help pay for health insurance, because wages would then fall below the legal minimum. *Studies suggest that, in 1989, about one-third of all uninsured American workers earned wages which, if reduced by the cost of health insurance, would fall below the legal minimum. Requiring employers to provide these workers with health insurance is likely to lead to increased unemployment among low-wage workers.*

## SUMMARY

- Spending on health care has been rising steadily, both in absolute terms and as a share of national income. Since 1960, spending on health care has also risen rapidly in other developed countries, but the per capita cost of health care is much higher in the United States than in other developed countries.
- The number of uninsured has increased recently. Part of this increase is due to the economic slowdown, while part is due to a long-term decline in employer-sponsored health insurance.
- The uninsured are poorer and younger, on average, than the insured. Although most are in good health, some are chronically ill. The uninsured do receive some health care, but they receive less than those with insurance and often receive care in emergency rooms. Out-of-pocket health expenditures among

the uninsured are lower than among insured people with similar incomes.

- Many of the uninsured are workers employed by small firms. A substantial fraction of uninsured workers earn wages which, if reduced by the cost of health insurance, would fall below minimum wage. Requiring employers to provide insurance to these workers would lead to increased unemployment.

## ECONOMIC THEORY OF THE HEALTH CARE MARKET

Economic analysis can help explain much of the recent performance of the American health care market and the problems that have emerged. Providers and purchasers of health care services respond to the incentives and restrictions they face, which stem from both the nature of health care itself and the way it is financed and delivered.

### PROVIDING HEALTH CARE SERVICES

Two features of health care provision have significant implications for costs. First, it is difficult for consumers to evaluate the quality of health care services. They rely on the advice of the provider of the service in deciding what to buy. While the lack of independent information is not unique to the health care market (car owners may rely on mechanics), it can lead to the unwitting purchase of unnecessary, poor quality, or high-cost services.

Second, to protect consumers from unscrupulous or incompetent providers, licensing boards in every State regulate those who work in health care. The licensing procedure can increase the price of services by restricting the number of providers and limiting the ways that they may compete.

### PROBLEMS OF MEASURING QUALITY

Physicians have much more information about treating a particular illness than their patients do. Patients may find it difficult to evaluate their treatment; if they get better, they may not be able to tell whether they have enjoyed a natural recovery or especially effective treatment. Lack of information can make it difficult for people to make decisions about purchasing health care. A physician could charge a low fee either because the services are provided in the most cost-saving way or because they are not performed properly.

People have tried to overcome this problem by evaluating a primary care physician—asking for recommendations from friends, for example—and then accepting the primary care physician's advice on further treatment. But friends may not be able to assess quality accurately; their advice may be particularly deficient in evaluating the services of a group of doctors in a coordinated care organization.

Information about provider quality is especially important because of the enormous variation in the way American doctors treat patients with similar problems. For example, rates of use of some discretionary procedures, such as tonsillectomies, can be ten times as high in one county as in a neighboring county with a similar population. In many cases, the use of such procedures deviates substantially from what experts recommend. Rates of mortality for patients with similar problems also differ considerably among hospitals.

*These variations suggest that if consumers could better evaluate their care, the quality of care could be improved substantially and costs could be reduced. Physicians and hospitals that offer low-quality care at high prices would face stronger incentives to improve quality and reduce costs.*

### *Improving the Quality of Information*

Without a reasonably accurate way to measure quality, health care plans, hospitals, and providers have a difficult time competing on the basis of the price of services they offer. But developing such information may not make economic sense for any single health care provider or insurer, since setting up a system of gathering and disseminating information would be costly and, once developed, might well be copied. The tax treatment of employer-provided insurance and the government's growing role in health care provision have also limited the incentives for private insurers and providers to develop ways to compete by providing high-quality, low-cost care.

Despite these impediments, insurers and employers have recently been working together to develop systems for measuring the quality of health care provided. The Federal Government has launched a major initiative with the publication of mortality rates (adjusted for the severity of patient illness) for medicare patients in U.S. hospitals. A variety of other groups are providing information in health care markets, including a group that publishes an annual guide to Washington-area Federal employee health plans; the Pennsylvania Health Care Cost Containment Council, which publishes information about hospital charges and mortality rates; and a group of employers in Cleveland that sponsors the Cleveland Health Quality Choice Project, which is developing measures to compare the quality of care in Cleveland-area hospitals.

## THE SUPPLY OF PROVIDERS

In many industries, costs rise when the necessary skilled personnel and materials are in short supply. In most cases, such short-term shortages cause wages to rise, attracting new supplies of skilled workers. Shortages and the high wages that they produce are unlikely to persist over time. High physician incomes might persist, however, without leading to an increased supply of doctors, because the medical profession can, to some extent, regulate the number of new physicians receiving licenses each year.

In the past, physicians' associations have also kept doctors from competing on the basis of price. Until 1982, these organizations restricted their members' ability to advertise services. For many years, professional associations controlled the types of fee arrangements that doctors could accept, stifling the growth of coordinated care. These problems are less serious today. The number of practicing doctors has increased greatly and the profession's ability to limit price competition has declined.

## HEALTH INSURANCE

The need for health care depends, in part, on somewhat unpredictable and costly events, such as a serious illness or accident. People can respond to the risk of such possibilities by self-insuring, or saving money to pay for potential expenses; by investing in preventive health care; or by purchasing health insurance.

Insurance is most valuable when it protects people against uncertain events that carry a high risk of substantial financial loss. Thus, early insurance plans were set up to cover costly hospital expenses. By 1960, insurance covered most hospital care, but people generally paid for other services themselves. In recent years, however, insurance coverage has expanded to cover other services. The share of out-of-pocket expenses for relatively predictable and inexpensive services (such as physician services, dental care, and pharmaceuticals) has been declining steadily (Chart 4-6).

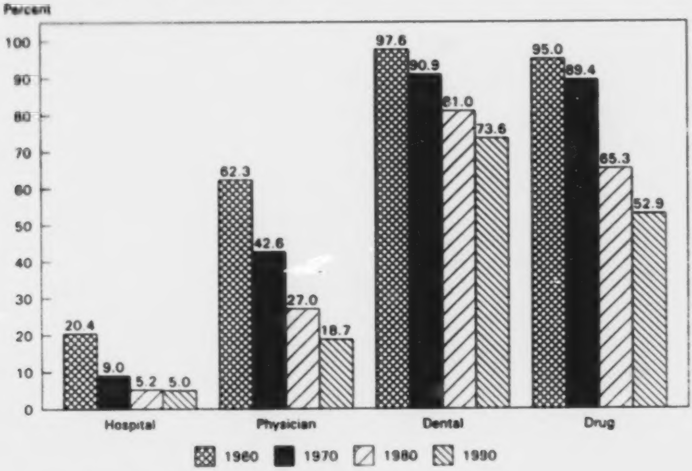
### *Insurance can Lead to Overconsumption of Services*

All insurance, whether privately or publicly provided, affects the incentives of the insured. Because they are protected against the full cost of a serious illness or injury, the insured have less incentive to take steps to limit the losses associated with such events. The change in incentives that results from the purchase of insurance is known by economists as "moral hazard." To economists, the term carries no connotation of dishonesty.

Moral hazard typically refers to a reduction in the incentive to avoid undesirable events. For example, people insured against car theft may leave their doors unlocked, increasing the chance that their cars may be stolen. People with health insurance may be just as careful as the uninsured about avoiding health risks, but they also respond to the incentives produced through insurance by using more health care services. They are likely to go to the doctor more often and choose more complex procedures. Among health econo-

Chart 4-6 **Share of Health Care Expenses Paid Out of Pocket**

The share of expenses paid out of pocket varies considerably among services but has been declining since 1960 for all services.



Source: Health Care Financing Administration.

mists, the term moral hazard has come to include this incentive for the overconsumption of health care services, which adds to total health care costs.

Studies suggest that the overconsumption of services due to moral hazard is an important factor in rising health care costs. One study in the 1970s gave one group of randomly selected families health insurance policies that provided them with full insurance for all health care services and another group a catastrophic health insurance plan and a corresponding cash payment (for example, a health insurance policy with a $1,000 deductible together with a cash payment of $1,000). Although both families were equally well indemnified, those who were fully insured used nearly 30 percent more services than those with the catastrophic insurance plan. According to most measures of health status, families in both groups were equally healthy at the end of the 3 to 5-year experiment.

### *Responses to Moral Hazard*

Because people with insurance pay less than the full cost of insured services, moral hazard suggests they may use services that they would not have chosen to purchase if they had to pay the full cost. But by using these additional services, policyholders drive up the cost of insurance. Ultimately, they pay the full expected cost of these additional services through higher insurance premiums. Yet many consumers would prefer less expensive insurance policies that encourage them to use only those services that they value most highly.

Insurers have two well-known ways to limit the potential response to moral hazard in their policies and keep premium costs down. Traditionally, they have required those with insurance to pay for part of their services through deductibles and copayments. Even with deductibles and copayments for a particular service, however, the price an insured patient pays for services will generally be less than the full cost.

Another response to moral hazard involves monitoring policyholders to ensure that they are taking appropriate preventive measures and to cap the services that they can use if an illness or injury occurs. By monitoring services and encouraging preventive care, the insurer can try to restrict the policyholder to only those services that are worth their full cost. Coordinated care organizations take this approach. These organizations typically charge low copayments and deductibles but closely monitor the utilization of health care services among those who are ill and often provide free preventive care services. Conventional insurers have also begun to adopt these monitoring practices, for example, by requiring a second opinion for surgery.

### *Using Private Information in Purchasing Insurance*

People usually know more than insurance companies about their own health and their need for health care services. This asymmetry of information has important implications for the health insurance market. An insurer charges a premium based on the average need for health care services. For those who anticipate that their need for health care services will be higher than average, health insurance is a bargain. But those who anticipate that their need for health care services will be below average may find health insurance a poor investment. They may choose to pay for their health care themselves or to purchase a health insurance policy with very high deductibles and copayments. This process is known as adverse selection.

If those at low risk drop out of the health insurance market, the average premiums for the remaining purchasers will rise. In theory, if the adverse selection process continues, the market for insurance may disappear altogether as healthier people decline increasingly expensive insurance. Alternatively, people may sort themselves into high- and low-risk groups and purchase different kinds of insurance. If this occurs, *those at high risk will purchase comprehensive health insurance plans and face premiums that re-*

*flect the full costs associated with their true health status. Low-risk individuals will purchase less comprehensive insurance, paying low premiums that reflect both the type of plan they purchase and their health status.*

Economic theory suggests that adverse selection can lead to lower levels of health insurance coverage for the relatively healthy. Studies also support this finding. Among firms offering multiple health insurance plans, premiums for comprehensive coverage are much higher than premiums for plans with high deductibles and copayments. These higher premiums are not fully explained by the fact that comprehensive plans offer additional services or by the effects of moral hazard. Rather, evidence suggests that those who choose the comprehensive plans are in poorer health than those who choose plans requiring high out-of-pocket payments.

The theory of adverse selection can also explain some characteristics of the uninsured. For example, the uninsured appear to have a low propensity to use medical services. When currently uninsured people obtain insurance, they use, on average, fewer services than those who are continuously insured.

## CONCERNS OVER THE DISTRIBUTION OF MEDICAL RESOURCES

Asymmetries of information, whether between insurers and policyholders or providers and patients, can cause problems in the health care market. Consequently, some people will not be able to purchase insurance, and some patients willing to pay for better care will not be able to find it. But even if these asymmetries could be eliminated, health care would still be costly. Some Americans, especially those who are poor or who have chronic health conditions, would still find it very difficult to purchase health insurance.

### *Risk Selection*

Private insurers compete to offer people the lowest price for their health coverage. One way to offer a better bargain to people with lower-than-average health risks is to adjust the price of insurance offered to them to reflect only the cost of the health services they can be expected to purchase. If insurers can observe the risk characteristics of those they insure, they can charge these low-risk people low premiums. People at high risk would be charged high premiums that reflect all the costs they could be expected to incur.

People with chronic health conditions may be excluded from commercial health insurance coverage due to preexisting condition clauses. If they are able to find coverage, they are likely to be charged very high rates that correspond to their expected health costs. Ironically, improvements in diagnostic and management technology may make it even harder for some people to obtain health insurance, as insurance companies become better able to diagnose and screen out those with chronic health problems.

*If insurers are required to charge all purchasers of health insurance in a community the same premiums (a practice known as community rating), they are prevented from responding to even readily observable health characteristics by raising or lowering prices. Yet these insurers will still try to compete by offering low prices to those at low risk. They may do this by directly refusing to provide coverage to those at high risk, a practice called risk selection. Alternatively, they may use adverse selection to their advantage, selling low-priced insurance contracts with restricted services or high copayment rates that appeal to those at low risk but would not be chosen by those at high risk.*

### *Health Care for the Poor and Ill*

The unequal distribution of health care is an important policy concern. Most Americans believe that everyone should be entitled to at least basic health care, regardless of income or health status. This belief distinguishes the health care sector from most other parts of the U.S. economy and explains why charitable organizations have always played an important role in health care. Public and voluntary hospitals continue to provide, to some extent, a health care safety net that ironically causes other problems in the health insurance market.

First, because this safety net operates principally through hospital emergency rooms, most of the uninsured receive care only when their conditions are quite serious, although more effective care could often be provided earlier in the course of their illness. Furthermore, providing emergency care through hospitals is likely to be much more costly than providing preventive care in an outpatient setting.

Second, although most Americans agree that everyone should receive basic health care, the safety net does not force all Americans to share the burden of this care equally. Instead, the costs may fall on those who use hospitals that charge high fees to paying patients in order to cover the cost of the uninsured.

Finally, the existence of the safety net may discourage some people from purchasing health insurance, especially those with serious health conditions who must pay very high premiums and those in very good health who do not expect to use services at all. For these people, remaining uninsured may be better than purchasing insurance because they know that they will not be turned away if and when they need care.

Unfortunately, programs that help low-income people purchase health insurance can also have some undesirable effects. As family incomes rise, support under income-tested health programs is phased out. As with similar provisions in other government programs (such as aid to families with dependent children), this phase-out means that poor families may face a very high marginal "tax" rate. Small increases in their income are accompanied by large reductions in the value of the health care and other support they receive. Such high taxes may discourage people from trying to increase their incomes.

## SUMMARY

- A lack of information may lead patients to spend money on services they might not choose if they were fully informed. Private and public initiatives are underway to improve the quality of health care information.
- Health insurance reduces the price of health care services for policyholders. Thus it can lead to the overconsumption of health care—that is, the use of services whose full costs exceed their benefit to the consumer.
- When policyholders have more information about their own health status than do insurers (or than insurers are permitted to use), adverse selection—which may cause the healthiest people to opt out of the health insurance market—may occur.
- The existing safety net for the uninsured is problematic. The uninsured receive insufficient and often inappropriate forms of care and have few incentives to purchase insurance.

## WHY ARE HEALTH CARE EXPENDITURES INCREASING?

An economic analysis of the structure of the U.S. health care market can help to explain why health care expenditures have risen so sharply. The tax subsidy for health insurance has encouraged employers to provide employees with coverage that includes very low copayments and deductibles and covers relatively predictable and inexpensive services. Most people covered by government insurance programs (medicare and medicaid) also make low out-of-pocket payments. Although substantial out-of-pocket payments are required in the medicare program, most beneficiaries have medigap policies that cover many of these costs. Out-of-pocket payments for health care as a share of all health expenditures have been falling, reducing the incentive for consumers to limit their use of health care services. For example, studies show that, at current levels, medigap insurance increases health care utilization by up to 24 percent.

The open-ended nature of health insurance contracts means that most new nonexperimental technologies will be covered by existing policies. As a result, expensive new technologies covered by insurance may be introduced before consumers would otherwise be willing to pay for them, further contributing to the escalation of costs.

## PRICES AND QUANTITIES OF HEALTH CARE

The Health Care Financing Administration, the Federal agency that administers medicare and medicaid, has developed a price index for personal health care expenditures that measures the cost of all health care services, regardless of who pays for them. Dividing total spending on health care by this price index produces a composite measure of the quantity of the various health care services people consume, including physician visits, hospital care, and drug purchases.

Two factors affect the price index: changes in the economy's general inflation rate and deviations in the price of health care services from the general rate of inflation. Table 4-1 provides measures of changes in total health care expenditures and divides these into changes in economywide prices, real health care expenditures, health care prices in excess of economywide inflation, and quantities of health care consumed.

TABLE 4-1.—*Average Annual Percent Change in Personal Health Care Expenditures Per Capita, Prices, and Quantities: 1960–90*

| Item | 1960-70 | 1970-80 | 1980-90 |
|---|---|---|---|
| 1) Personal health care expenditures per capita | 9.2 | 11.9 | 9.2 |
| 2) MINUS Economywide inflation | 2.2 | 6.2 | 4.6 |
| 3) EQUALS Expenditures per capita corrected for inflation | 6.9 | 5.4 | 4.4 |
| 4) MINUS Health care price increases in excess of inflation | 1.7 | 1.6 | 2.3 |
| 5) EQUALS Quantity of health care per capita | 5.1 | 3.8 | 2.2 |

Note—Columns do not sum both because of rounding and because the price-quantity interaction terms have been omitted.
Source: Health Care Financing Administration.

This price index for health care expenditures, like other price indexes, is constructed by examining the cost of a basket of commodities or services over time. The personal health care price index basket includes hospital care, physician services, drugs, and other health-related products. The index reflects changes in the cost of this broad basket, not the price of a particular service provided by a hospital or physician.

*The price index does not adequately reflect improvements in the quality of the commodities or services, which usually appear as price increases.* For example, total expenditures for a hospital day go up if the number of nursing visits made during that hospital day increases. While such a change implies that the quality of a day in the hospital has improved, it appears only as an increase in the health care price index. An alternative way to measure changes in health care expenditures is described in Box 4-5.

**Box 4-5.—Measuring Changes in Health Care Expenditures**

Measures of the cost of health care often fail to account for changes in quality. An alternative method for measuring health care costs, proposed in a [illegible] study, suggests a way of overcoming this problem by measuring the cost of treating a particular ailment over time. For example, the study compared the cost of treating an ear infection in 1971 to the cost of treating an ear infection in 1981 (in real dollars, the cost fell). The study also suggested that the costs of treatment should be adjusted to reflect higher cure rates.

Why isn't this more appropriate method in wider use? One reason is that it is computationally very difficult to measure the full cost of treating an ailment. Moreover, even this method does not capture all the changes that may have been made in medical technology. Important advances in health care have not only improved the technology for treating some diseases but, in many cases, reduced their overall incidence. At the same time, diseases exist today that were unknown in 1960. Even this modified method does not reflect the full effect on costs either of improvements that reduce the incidence of disease or of new diseases.

## RECENT INCREASES IN HEALTH CARE EXPENDITURES

U.S. health care expenditures have risen continuously since the 1960s, not only because health care prices have gone up but because Americans are using more services. In the 1980s, real health care spending grew more slowly than it had during the preceding two decades. Growth was split evenly between increases in the quantity of health care consumed (2.2 percent annually) and increases in the health care price index in excess of general inflation (2.3 percent annually) (Table 4-1).

Economic theory suggests that when prices rise people usually consume less of a good or service. Yet the price of health care and the quantity purchased rose in tandem during the 1980s (as well as in earlier decades). These concurrent increases in price and quantity are consistent with the view that the quality of health care changed during the 1980s. Consumers in 1990 were probably not buying more 1980-style health care at 1990 prices; rather, they were willing to pay more for 1990-style health care than they had been willing to pay for 1980-style health care. The changes that were measured in quantity and price hid underlying changes in quality.

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The quantity of health care services consumed increased primarily because of greater use of outpatient and physician care in the 1980s. The growth rate of inpatient hospital spending declined between 1982 and 1986, largely because of changes in the system of medicare reimbursement. Although inpatient hospital services are now paid prospectively, outpatient services for medicare continue to be paid on a less constraining retrospective basis, giving hospitals a considerable incentive to move procedures from an inpatient to an outpatient setting.

The health care sector responded in a flexible and rapid way to this changed incentive. In 1980 only 16 percent of surgeries in short-stay hospitals were performed on an outpatient basis, but by 1989, 49 percent were conducted on an outpatient basis. The potential for such responses needs to be taken into account in the development of health policy.

## COMPONENTS OF PRICE INCREASES IN THE 1980s

The health care price index increased throughout the 1980s. Price increases measured were due, in part, to increased use of expensive technologies and to changes in the cost and types of labor used in health care. As insurers and providers competed by offering more generous coverage, technology, and high quality care, costs rose.

### *Physician Costs in the 1980s*

In the late 1980s, physician costs rose more rapidly than other major components of health care spending, in part because of an increase in the use of outpatient diagnostic and treatment facilities, some of them owned by physicians. Studies suggest that physicians order more tests when they own a share in diagnostic and treatment facilities. These private facilities may be more convenient, but physicians may also be motivated by the incentives created by the traditional insurance system, which pays physicians for each service they provide—including those provided by diagnostic and treatment facilities that they own.

This practice may be curtailed by regulations stemming from the 1988 Clinical Laboratory Improvement Amendments. The act, intended to improve the quality of laboratory tests, imposes very costly regulations on the operation of laboratories. But these regulations may not significantly improve the quality of health care and, in fact, may impose additional costs on patients whose physicians operate small-scale office-based laboratories.

U.S. physicians became, on average, more highly specialized during the 3 decades leading up to 1990, especially before 1980. In 1965 24 percent of U.S. physicians were general practitioners. By 1990 only 12 percent of U.S. physicians were general practitioners; the other 88 percent were specialists, a much higher percentage than in other countries, such as Canada. Specialists are usually more highly paid than general practitioners, and the pay differential expanded during the 1980s as the demand grew for new diagnostic and surgical procedures only specialists can provide.

### *Nursing Costs in the 1980s*

In the early 1980s, salaries for nurses were low compared with those for other occupations requiring similar levels of skill, discouraging some qualified applicants from entering nursing school. In an effort to attract more nurses, hospitals increased nurses' real wages. Between January 1980 and January 1990, the real hourly earnings of private hospital employees rose about 25 percent (excluding the value of nonwage compensation), while the earnings of all private sector workers changed little. Registered nurses were among those hospital employees receiving the largest pay increases during the 1980s. At the same time, reductions in the length of the average hospital stay and increased use of outpatient surgery meant that patients who were admitted and kept in hospitals were, on average, sicker than those admitted in 1980. Hospitals were forced to increase the ratio of highly skilled registered nurses to patients in order to maintain the quality of their services.

### *Medical Technology in the 1980s*

Increased use of costly medical technology also had an important impact on measured health care prices in the 1980s. *Between 1980 and 1990, for instance, the number of computerized axial tomography (CAT) scans performed in short-stay hospitals in the United States increased over 400 percent. The number of community hospitals with magnetic resonance imagery equipment rose 500 percent between 1984 and 1991.* Many of these new technologies also proliferated in nonhospital settings.

The use of new surgical techniques flourished in the 1980s. For example, *in 1980, 1 in every 400 American men aged 65 and over had coronary artery bypass surgery. In 1990, about 1 in 100 American men in the same age group had this form of surgery.*

### *The Costs of Malpractice Litigation*

The increasing costs associated with medical malpractice suits have been an important factor in rising health care costs. Between 1982 and 1989, doctors' liability premiums, the principal source of payment for malpractice claims, grew at 15 percent annually, faster than any other component of medical practice costs. Another more insidious effect of malpractice suits is that they may compel physicians to perform tests that are not cost-effective simply to protect themselves from legal actions. The costs of defensive medical practices have been estimated at over $20 billion in 1989 alone, or almost 18 percent of total physician expenditures. Finally, malpractice insurance costs have caused some physicians to drop out of some specialties, such as obstetrics, making such specialists hard to find in some communities.

Although insurers and physicians spend large sums defending themselves in malpractice suits, relatively little of this money makes its way to those injured through negligence. A recent study of malpractice cases in New York found that 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system. In 1984, only about 60 percent of the money expended on malpractice litigation was actually paid to injured plaintiffs.

### *Administrative Expenditures*

The administrative costs of the U.S. health care industry, which are estimated at $80 billion in 1991, have been widely criticized and unfavorably compared to the costs of administering the government-run systems in many other countries. Private insurance companies incur costs marketing their products, reviewing and processing claims, and screening and establishing the health status of potential enrollees. Billing individual patients or insurance companies raises costs for physicians and hospitals.

Recent studies find, however, that shifting to a system that eliminates the functions of the U.S. private insurance industry would result in few overall cost reductions. Most of the administrative cost savings would be offset by increases in utilization that would come from the elimination of features of the current system that reduce overall expenditures, such as patient payments and insurance company oversight. In other countries with multiple insurers, such as Germany, administrative costs as a share of total health expenditures are comparable to those in the United States.

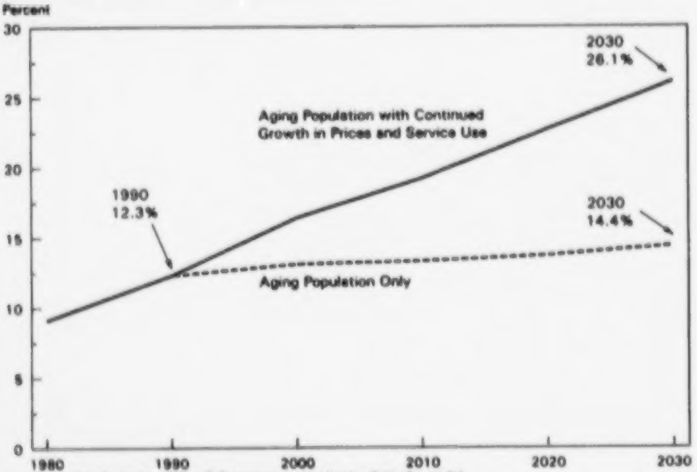
Private insurance companies compete, in part, on the prices of the services they offer. A competitive insurance company, like any other firm, can increase administrative expenses only if the benefits of these expenditures exceed the new expense. *In health insurance, much of the increase in administrative expenditures has come from the expansion of programs that monitor service utilization, and health insurance that offers these features is cheaper than insurance that does not—despite the administrative costs associated with oversight programs.* Nonetheless, some of these costs, such as the costs of assessing the health status of new enrollees, may raise aggregate health care expenditures.

## PROJECTIONS OF FUTURE COST INCREASES

Many analysts expect that unless the health care market is substantially reformed, costs will continue to rise rapidly into the next century. Recent projections suggest that health care, which consumed 12 percent of the GNP in 1990, may rise to as much as 16 percent of GNP by the year 2000 and to 26 percent by 2030 (Chart 4-7).

Chart 4-7 **Projected Health Care Expenditures as Percent of GNP**

Most forecasts suggest that health care expenditures will continue rising, mainly due to increases in prices and in the use of services.



Note: The figure for 1990 (12.3 percent) is a projection from the model.
Source: Health Care Financing Administration.

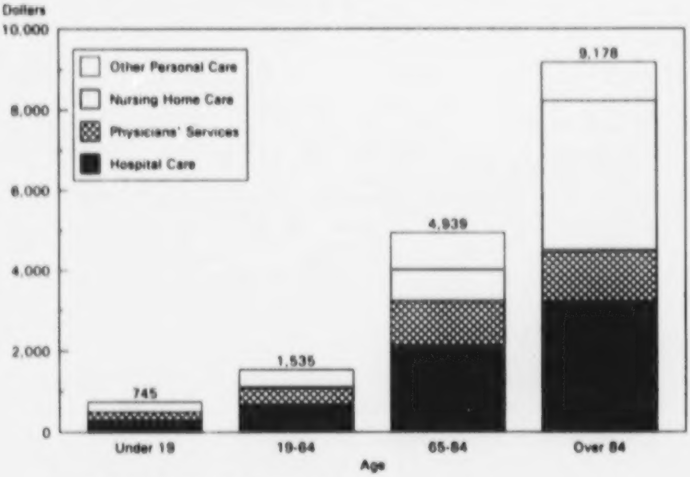
*These projected increases are due primarily to an expected continuation of the historic trends of increasing health care prices and volume consumed, as well as improving quality.* Because most projections of health care expenditures are based mainly on mechanical extrapolations of past trends, *they do not take into account changes in government programs or other individual and institutional responses to the rising cost of health care.* During the 1980s, as health care expenses rose rapidly, insurers, employers, consumers, and the government responded through innovations in the financing and delivery of care. Such changes in behavior, which cannot be captured by the modeling techniques currently in use, could have profound effects on the cost of health care.

## *Demographics*

Projected increases in health costs are, to a small extent, a consequence of the aging of the population. Population aging alone is expected to cause health care expenditures to increase from 12 percent of GNP in 1990 to about 14 percent by 2030, explaining about one-seventh of the total projected increase in health care costs (to 26 percent of GNP). The number of Americans over age 64, the age group for which health care spending is the highest, will increase through 2030, especially after the turn of the century.

Those over age 64 consume about 3½ times as much health care as those between the ages of 19 and 64, and those over age 84 consume almost 2½ times as much health care as those between the ages of 65 and 69 (Chart 4-8). Health care spending is higher among those over age 64 due primarily to the increased probability of death at this age. Health care spending is especially high in the last year of life. The 5 percent of aged beneficiaries who were in their last year of life accounted for 29 percent of medicare expenditures in 1979.

Chart 4-8 **Per Capita Personal Health Care Expenditures, by Age: 1987**
Health care expenditures, especially for nursing home care, rise rapidly with age.



Source: Health Care Financing Administration

Another important reason for the high costs of caring for those over age 64, and especially for those over age 84, is nursing home care. But because people who pay directly for much of this care, as well as State governments, which both pay for care and license nursing homes, have strong incentives to limit spending, most analysts expect the growth in spending for nursing home care to be slower than the changing age composition of the population would suggest.

## SUMMARY

- Both the price of health care and the quantity of services consumed increased during the 1980s. Part of the apparent increase in price was due to improvements in the quality of care. Labor costs, the costs of new equipment, and the use of new treatments all contributed to the growth in expenditures during the 1980s.
- Changes in administrative expenditures are unlikely to have been an important contributor to overall expenditure growth. Most administrative expenses reduce overall health care costs.
- Litigation over medical malpractice raises costs directly and encourages the practice of costly defensive medicine.
- Simple extrapolations of health care expenditures—which do not take cost-cutting measures into account—suggest that they will consume as much as 26 percent of gross national product by 2030. A small part of this increase is due to the aging of the population.

# PROPOSALS FOR REFORM OF THE HEALTH CARE MARKET

Increasing health care expenditures and the growing number of uninsured in the United States have led to a proliferation of proposals for health care reform. In the past year, some 70 bills have been introduced in the Congress. While most of these plans seek to alleviate the symptoms of trouble in the health care market, relatively few address the underlying causes of the cost increases and insurance gaps.

As the response to the diagnosis-related group payment system in hospitals has shown, changes in incentives can lead to major modifications in health care provision. *Because the health care sector is flexible and responsive, health reforms that address underlying economic problems and provide sound incentives can be very effective. On the other hand, reforms that ignore the economics of health care are likely to lead to unexpected and undesirable results.* Table 4-2 provides a summary of the main proposals for health care reform that are discussed below.

## ADMINISTRATION PROPOSAL

This Administration's health care reform proposal is a comprehensive, market-based reform plan that builds on the strengths of the existing market. It includes components designed both to expand access to health insurance and to improve market functioning.

TABLE 4-2.—*Side-by-Side Comparison of Health Insurance Plans*

| Issue | Administration Proposal | Managed Competition Proposal | Pay-or-Play and Rate Setting | National Health Insurance and Global Budgets |
|---|---|---|---|---|
| *Cost containment* | | | | |
| Moral hazard | Encourages managed care for public programs. | Promotes use of basic benefit package. | — — | — — |
| Other | Increases competition in small group market and public programs.<br>Improves availability of health care quality information.<br>Simplifies recordkeeping and billing.<br>Reduces malpractice litigation costs. | Increases competition in small group market. | Provider and hospital fee schedule. | Global budgets.<br>Physician and hospital fee schedule. |
| *Access* | | | | |
| Poor | Provides low and middle income people with insurance certificate/deduction. | Mandates coverage through employers.<br>Provides subsidies to low income people who are not employed and to part-time workers. | Requires employers to offer insurance or pay into public plan. | Universal coverage |
| Ill Health | Implements health risk adjusters for high-risk people in individual and small group health insurance markets. | Provides age-adjusted community-rated coverage in individual and small group health insurance markets. | Covers employed persons in ill health. | Universal coverage. |

## *Access to Care Under the Administration Proposal*

An important objective of health care reform is to provide better access to health care for the poor and those with chronic illnesses. The Administration's plan would address this objective by providing these groups with the funds to purchase health insurance within the existing health care market at a reasonable price. It would provide low-income Americans with a transferable tax credit, ranging from a maximum of $1,250 for single persons to $3,750 for families of three or more, for purchasing health insurance. Those who do not file tax returns would receive the credit in the form of a transferable health insurance certificate. Middle-income people would be eligible for a tax deduction for health insurance.

The U.S. Treasury estimates that, when fully phased in (in 1997), the health insurance tax credit and deduction could benefit about 90 million people. About 25 million of these potential beneficiaries would be low-income people receiving the maximum applicable credit. The credit or deduction would be reduced for those with higher incomes: 10 million people with incomes between 100 and 150 percent of the poverty level would receive a partial credit or deduction, and 56 million middle-income individuals would receive a partial deduction.

States would develop basic insurance packages equal to the value of the health insurance credit. Each State would ensure that at least two insurers offered such a package. Because low-income

Americans would be able to purchase basic insurance using their tax credits, they would no longer have to rely on the public hospital safety net. At the same time, the fixed-dollar nature of the credit or deduction would not encourage overconsumption of health insurance. While the credit or deduction could be used toward the purchase of plans offering other than the basic benefits, the purchaser would bear any additional cost of these plans.

The President's plan encourages States to fold their existing medicaid programs into the new program. Those eligible for medicaid would receive the full individual tax credit and could then purchase basic benefit coverage through one of the plans offered in the State. This scheme would allow even the poorest Americans a choice in their purchase of health insurance.

The plan would further expand health insurance coverage by helping small firms buy insurance. It would promote the use of health insurance networks to act as group purchasing agents for smaller employers, obtaining more favorable premiums and reducing administrative expenditures. Insurance purchased through these networks would be exempt from State-mandated benefits and premium taxes.

The plan would incorporate health risk pools that would spread the cost of serious health problems among all those purchasing health insurance with the tax credit or deduction or through the small group health insurance networks. These pools would employ health risk adjusters (Box 4-6). This feature of the plan addresses the concern that those with poor health conditions should be able to purchase health insurance. Low- and middle-income people with chronic health problems would have greatly improved access to health care through this combination of tax credits and deductions and health risk pools.

Although health risk pools would not wholly eliminate the problem of adverse selection, they would enable people with poor health to purchase health care at reasonable cost. Under the Administration's plan, people would not be required to purchase health insurance. Those who know that their health is unusually good and are eligible for only a partial credit or deduction could choose to forgo the credit or deduction, not purchase health insurance, and continue to pay their own expenses or rely on the existing health care safety net. The only way to eliminate this problem completely would be to require everyone to purchase some health insurance.

Finally, the plan prohibits all insurers from excluding any individual or group from health insurance coverage because of a preexisting condition and requires insurers to renew the coverage of any previously insured group that complies with its insurance contract. These features of the plan would reduce existing impediments to labor market mobility among those with preexisting health condi-

**Box 4-6.—Health Risk Adjusters**

The health risk pools envisioned under the President's plan would incorporate a system of health risk adjusters intended to equalize the cost of insuring those who differ only with regard to health status. Insurers serving a pool each cover different groups of people. Those providing coverage to groups with more than the average number of health problems would receive a payment from the pool equal to the difference between the expected average expenditures of that group and the average expenditures of all people in the pool. An insurer providing coverage to a relatively healthy group would make a corresponding payment into the pool.

These payments would be age-group specific. Thus, younger people, who tend to be quite healthy, would face lower average premiums than older people, who tend to have more health problems. That means that implementation of a health risk adjuster system would not give younger people additional incentives to leave the health insurance market or increase transfers from the young to the old. (Chapter 6 contains a discussion of current intergenerational transfers.) At the same time, the health risk adjuster system would leave all people with the incentive to save money for their old age.

Health risk adjusters have two advantages over community rating. First, because the payments are based on average rather than actual expenditures, everyone has incentives to monitor his or her own use of care. People who consistently use more than the expected average amount of health care for someone of their health status would face higher rates than those who economized on their use of care. Under community rating, the actual costs of this additional care would be spread among all people with insurance. Second, under a system of health risk adjusters, insurers would have no incentive to deny coverage to people with chronic health conditions. Firms that insure only low-risk people would have to make payments into the health risk pool to subsidize firms that insure high-risk people. Under community rating, insurers could profit by discriminating against people with chronic health conditions.

Under the Administration's reform proposal, health risk adjusters would be phased in over a period of 5 years. Premium bands would be implemented during the phase-in period. Premium bands limit the difference in premiums that insurers can charge groups with different average health status. Further limits on rate increases would also be in effect during the transition to health risk pools and risk adjusters.

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tions and lower some of the administrative costs associated with the screening of prospective enrollees in small-group plans.

### *Cost Control Under the Administration Plan*

Other aspects of the Administration's proposal are designed to improve the functioning of both private and public insurance in the health care marketplace. The plan would increase incentives to use coordinated care delivery systems within the medicare and medicaid frameworks. It would provide both HMO and alternative coordinated care options to medicare beneficiaries and increase financial incentives for beneficiaries to join the HMOs. The plan would require States either to shift all nonelderly medicaid beneficiaries into coordinated care programs or to fold all medicaid beneficiaries into the tax credit and deduction program.

To improve the performance of the private health insurance industry, the Administration's plan would address the lack of information in health care markets by requiring States to implement programs to help make information about the cost and quality of medical services available to consumers. The Federal Government would assist the States by developing prototype systems to assist in data gathering and outcome comparison. Informed patients are more likely to choose providers and insurers who provide high quality services at reasonable prices.

Under the Administration's plan, administrative costs would be reduced in both the private and public health insurance sectors. The proposal calls for the Federal Government to work with the private sector in developing record-keeping and billing forms. These reductions in billing costs, in combination with the savings from reduced health status screening, could lower the total administrative costs of the health care system significantly.

The Administration's proposal would encourage competition among health plans. Because recipients of tax credits or deductions (including former medicaid recipients) would be able to choose between at least two plans available in every geographic area, competition between the plans would help ensure an adequate level of service. If one plan provided poor-quality service, those insured could choose another plan. States would also be encouraged to remove existing impediments to competition, such as regulations limiting coordinated care arrangements and mandating the inclusion of certain benefits in insurance plans.

Malpractice costs would be reduced under the proposal's comprehensive liability reform plan. The plan would provide States with incentives to cap the amount of allowable losses for damages other than loss of income and the cost of health care associated with an injury. States would be encouraged to employ systems of alternative dispute resolution, which may reduce the cost of adjudicating disputes. The Federal Government would also intensify existing efforts to create guidelines and quality standards for health care that, when adopted by a State, could be used by the courts to determine negligence. If the legal system relied on such standards, physicians would no longer have to practice defensive medicine. Standards could also improve the quality of care by keeping physicians informed about state-of-the-art treatments for particular conditions.

The most important component of the Administration's proposal with respect to improving health is its emphasis on prevention. The proposal calls for substantially increased spending for Federal preventive care programs and for an expansion of primary care health services to low-income communities. It also increases funding for programs aimed at encouraging Americans to make healthier choices with respect to smoking, physical fitness, and diet.

## MANAGED COMPETITION

Managed competition reforms are intended to improve the operation of the marketplace and expand the availability of employer-sponsored health insurance. Although managed competition has many market-oriented features, it would greatly increase the role of the government in the health care system and would limit the range of health insurance options available to Americans. Many types of managed competition proposals exist; the discussion that follows examines one version.

Managed competition is built around the "accountable health partnership," an organization similar to an HMO that would provide both health benefits and consumer information. Each accountable health partnership would be registered with a national health board that would monitor the insurance market.

The national health board would define a set of "uniform effective health benefits" that accountable health partnerships would be required to provide. *All insurers, both private and governmental, would be required to offer the same basic benefit plan. Competition would focus on providing these benefits in a cost-saving and medically effective fashion.*

With managed competition almost everyone would have health insurance coverage. The proposal would mandate employer-provided insurance for all full-time employees. Employers would be required to make a flat contribution to an insurer for each of their employees of between 50 and 100 percent of the cost of the minimum benefit package offered by the cheapest accountable health partnership in the area. An employee could use this money to buy this plan, a more generous plan, or a plan from a different accountable health partnership. Even healthy employees would no doubt find it in their best interest to purchase health insurance at only half the premiums, so the 50-percent minimum contribution requirement would help to limit adverse selection.

Small firms would purchase insurance through collective purchasing agents in each State. These purchasing agents would pool risks and charge community rates across all small employers, although premiums could be age adjusted. Only those small employers who joined these organizations would be able to claim tax exemptions for health insurance premiums.

States would contract with the collective purchasing agent to insure all part-time employees and other unemployed and uninsured people. For these people, the premium costs of the cheapest available plan would be subsidized using revenues from taxes on part-time employees and on those with independent incomes.

Each State's collective purchasing agent could contract with many accountable health partnerships, creating competition among them. The national health board would be responsible for ensuring that the agent and each participating accountable health partnership met accounting, insurance, and benefit standards.

The mechanism for cost containment under managed competition is competition among accountable health partnerships over the price of the minimum benefit package. Although people could choose any insurance package offered by any participating accountable health partnership as long as it included at least the minimum benefits, they would not be able to deduct from their taxable income more than the cost of the minimum benefit package offered by the cheapest accountable health partnership. This limit on the tax subsidy would encourage people to choose less comprehensive health insurance and efficiently run insurance plans, since they would face the full additional cost if they chose a plan whose price exceeded that of the lowest-priced plan. Requiring that insurers offer at least this benefit package would mean that low-risk people could not engage in adverse selection by purchasing minimal benefit packages that would never be chosen by those at higher risk.

Because of the central role of the minimum benefit plan in this proposal, the kinds of benefits and deductible and copayment levels included in the plan would be very important. The benefits would have to be designed to fit the services offered by both traditional health insurers, which typically use deductibles and copayments to limit moral hazard, and coordinated care organizations, which use fewer deductibles and copayments but tend to monitor service utilization directly.

To avoid risk selection, the national health board would either need to specify benefits in a way that would limit the ability of accountable health partnerships to avoid sicker-than-average people or implement a system of health risk adjusters. Unless they did so, insurers could avoid such people, for example, by locating their offices in buildings without elevators, or by contracting only with physicians who do not specialize in the care of costly conditions.

With managed competition the government would take an active role in selecting the basic benefit package and in defining the type of insurance that most people would be likely to purchase. These governmental decisions could change the insurance arrangements of many Americans, because the accountable health partnerships envisioned in the proposal are similar to HMOs, while most Americans are currently enrolled in traditional fee-for-service health insurance plans. These decisions will also have a profound effective on the financial future of providers and insurers, who are likely to press for benefits to be defined as broadly as possible, limiting the ability of managed competition to contain costs.

## PLAY-OR-PAY

Play-or-pay proposals for health care reform are structured around requirements that firms either provide basic health insurance to employees and their dependents ("play") or pay a payroll tax to cover enrollment in a public health care plan ("pay"). Most play-or-pay proposals would also offer sliding subsidies to those who are not attached to the work force.

Play-or-pay proposals focus on improving access to health insurance. But while play-or-pay would improve access to health insurance for some workers with low incomes or poor health status, it could reduce the incomes and employment opportunities of many other low-income people. Competitive firms would probably have to pass along the costs of health insurance to their workers in the form of lower wages. Thus, mandating health insurance through the workplace could lead to lower wages among currently uninsured employees and to increased unemployment among employees whose wages are at or near the minimum.

To the extent that employers choose to "play" rather than "pay," play-or-pay reform would retain some of the competitive aspects of the current health care market. Firms offering benefits similar to those offered in the public plan, however, would be able to switch to the "pay" option if the cost of their health insurance premiums is greater than the payroll tax. If the tax is set too low, everyone will eventually be enrolled in a single public plan. If the tax is too high, small employers will be forced to buy costly insurance, which will increase the plan's potential to lead to layoffs.

Play-or-pay alone does not directly address the problem of controlling health care expenditures. The effect of play-or-pay on costs would depend greatly on the structure of the public health insurance program, because a play-or-pay system would greatly increase participation in this program. Medicaid includes only limited provisions to reduce moral hazard. It has only recently launched managed care initiatives and, because it covers a population in poverty, currently incorporates few patient payment requirements. The public program in a play-or-pay system would need to include more patient payment requirements and managed care initiatives if costs are to be contained. Otherwise, play-or-pay could lead to increased overconsumption of medical resources, driving up health care costs.

Play-or-pay would provide health insurance to those with poor health conditions who may not be able to afford insurance in the current market. These people, however, are likely to be insured through the public program. Firms that hire workers with serious health conditions can avoid paying high insurance premiums by switching to the public plan. As a consequence, the cost of providing care in the public plan is likely to rise, and payroll tax rates may have to be raised to offset this increase. As the cost of health care rises, firms that are required to provide health insurance may begin laying off workers, especially low-skilled workers (as described above).

## NATIONAL HEALTH INSURANCE PROPOSALS

Proposals for national health insurance envision replacing the private health insurance market with a single national health insurer. This national health insurer would be funded through taxes and care would be either free (as in Canada) or provided at a low cost-sharing level. National health insurance would provide Americans, regardless of income or health status, with access to a centrally determined set of health care services, at no direct cost to the insured. Because everyone would have exactly the same health insurance, national health insurance avoids the problems of risk selection and adverse selection.

Although national health insurance would ensure access to health insurance for everyone, it provides few incentives for consumers to limit their use of services and could lead to an explosion in cost unless other substantial reforms were undertaken. National health insurance greatly reduces existing incentives for consumers to limit their use of care. In most proposals, the cost of health care is shared among all taxpayers with few deductibles and copayments. The Canadian experience and other evidence suggest that substantial increases in utilization would be likely to accompany such reductions in deductibles and copayments.

Some proposals for national health insurance envision saving money by reducing administrative costs, but since reductions in administrative costs are likely to be accompanied by increased overconsumption of services, net health care costs may not decrease. National health insurance plans can control costs mainly by controlling the quantity and quality of health care supplied, often through price or budget controls (discussed below). An alternative way to control costs would be to fund only selected services, a method that has been proposed for the State of Oregon's medicaid program (Box 4-7).

Controls on supply and reductions in administrative costs are easiest to achieve in national health insurance programs that do not allow people to opt out by purchasing private health insurance. Adding any degree of choice to a national health insurance program—by allowing people to purchase alternative insurance, for instance—may reduce the cost savings achieved through supply controls and would be likely to increase administrative costs.

**Box 4-7.—Oregon Medicaid Waiver Proposal**

The State of Oregon has developed an innovative proposal that would extend medicaid insurance coverage to all Oregonians with incomes below the Federal poverty line. The plan would extend coverage to this broad group of people by restricting the treatments available to those covered. As proponents of the plan put it, services, not people, would be rationed.

In order to determine which services would be provided, the Oregon Health Services Commission undertook an extensive process that included research and analysis as well as consultations with the public. Initially, the commission identified 709 "condition-treatment" pairs, such as appendicitis-appendectomy. Next, the commission classified each pair into 1 of 17 categories according to the outcomes that could be expected from the treatment, such as "prevents death with full recovery," and ranked the pairs within each of the categories according to their impact on the quality of life. Finally, the commission submitted the ranked list of 709 pairs to the State legislature.

The legislature appropriated funds to cover services 1-587 on the list. These condition-treatment pairs would be included in the basic medical plan. Those condition-treatment pairs ranked 588-709 would not be covered for those insured by medicaid in Oregon.

Because medicaid is funded jointly by the Federal Government and the States, Oregon had to apply for a waiver from the Federal Government in order to implement this plan. This waiver was denied to the current version of the Oregon plan in August because of concerns that it violated the rights of the disabled under the Americans with Disabilities Act.

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## RATE SETTING

Some play-or-pay and national health insurance proposals incorporate provisions for rate setting. Rate setting, currently in use for hospital billing in some States, means that a governmental agency sets a single schedule of health care prices on which all payments, whether private or public, are based. In practice, increases in utilization often accompany such restrictions on prices in the health care market, limiting their effectiveness as a method of cost control. Because of the difficulty of measuring prices and quantities of health care, providers of health care services can easily change the quantity of health care services they report to accommodate lower prices. For example, an increase in the number of diagnostic tests provided to a patient will appear to be an increase in the per-visit price if all the tests are provided during one visit. This same increase will appear as an increase in quantity, rather than as a price hike, if the tests are spread over multiple visits.

Problems in measuring units of health care services make the enforcement of price controls in this sector troublesome. The Canadian experience suggests that the implementation of price controls in a fee-for-service physician payment system is likely to be accompanied by large increases in office visits. For example, physicians could require their patients to make office visits to get the results of tests, rather than simply conveying this information over the phone or by mail. Doctors could refuse to do more than one procedure per visit, requiring the patient to come back again for a second procedure, in order to get a second fee from the government. Studies of the Canadian system suggest that very substantial amounts of patient time are wasted through unnecessary trips to the doctor.

Experience from other industries suggests that if price controls could be enforced, they would likely lead to shortages of desired services. Initially, rates may be set to reflect the availability and need for services. But over time, the bureaucratic process of setting rates may mean that changes in the provision of, or demand for, services are not captured by new rates. When conditions change, the old rates are likely to cause shortages.

## GLOBAL BUDGETS

A frequently recommended proposal for controlling expenditures in the health care system has been global budgets that cover all health costs. Global budgets would fix the sums health care providers throughout the U.S. economy can spend.

It would be very difficult to implement global budgets in the fragmented health care sector that now exists. For example, a global budget would have to account for out-of-pocket payments made by consumers, fee-for-service payments made by conventional insurers, per capita payments made by HMOs, and the provision of uncompensated care in emergency rooms. They would have to allocate funding across regions, States, and cities, although currently spending varies considerably in different localities. Most global budget plans would begin by implementing price controls—for example, setting payment levels for diagnosis-related groups and for HMOs—but as noted above, such controls are likely to lead to increases in utilization.

Global budgets could also be applied to individual hospitals, independent of the amount of service provided. Such budgets would create incentives to reduce the services within a hospital and could lead to delays in admitting patients, or reductions in the use of effective but costly medical technologies.

Under global budgets there would be few incentives for providers to compete by developing better ways to deliver care. Improvements in health care delivery would be made primarily by government mandate. The government would take a very active role in deciding how much health care would be provided, stipulating the number of practicing physicians, the number of hospital beds, and the availability of new medical technologies and treatments.

Such government-determined supply-side controls could also lead to inappropriate decisions at the level of the individual provider. For example, hospitals are likely to find it easier to stay within their annual budgets if they keep their hospital beds filled with patients who have already recovered, rather than admitting sicker patients. Global budgets for physicians may lead doctors to restrict their hours and increase their vacation days rather than providing cost-effective care. Efficient physicians can be penalized if global budgets lead to across-the-board cutbacks in spending on care.

## POLITICS AND HEALTH CARE

Most proposals for reform of the health care market envision a larger governmental role. For example, under the Administration's proposal, the Federal Government would define a basic benefit plan that could be purchased by recipients of the tax credit or deduction (although they could choose other plans). Under the managed competition proposal, government boards would define accountable health partnerships and the basic benefits people could purchase and still remain eligible for the tax subsidy. Such government-determined allocation decisions are likely to become politicized. Decisions about which services to cover and payments to make may be affected by the political influence of provider groups rather than by appropriate medical and economic considerations.

Governments already play an enormous role in the U.S. health care industry as regulators, purchasers, and employers. Federal, State, and local governments regulate virtually every aspect of the industry, from the supply of insurance to the practice of medicine to the sale of pharmaceuticals. In 1990 including the value of health-related tax subsidies, governments paid for about the same share of the output in this industry as in the aerospace industry. The three levels of government together employed more than twice as many health and hospital workers as postal workers.

Using government bureaucracies rather than markets to determine industry outcomes is usually wasteful and inefficient. The ordinary problems of regulation are magnified in the health care context for two reasons. First, setting quantities is difficult because of the enormous variation in people's need for and attitude toward medical care, a product that is constantly changing. Second, regulators have to rely on producer groups (including insurers, doctors, and hospital employees) and some consumer groups for information and support, and these groups share a proclivity to expand public and private expenditures at the expense of the general public.

## SUMMARY

- The Administration's proposal for health care market reform would expand the insurance coverage available to low-income and middle-income Americans.
- The use of health risk adjusters in the Administration plan can reduce differences in the cost of health insurance between people in good health and people in poor health. Unlike community rating plans, health risk adjusters limit the incentive for insurers to exclude those in poor health.
- Managed competition proposals would encourage competition among health insurers providing a basic benefit package. Managed competition requires that the government play a substantial role in the private health insurance market, monitoring insurers and defining the benefits that most Americans would receive.
- Play-or-pay proposals focus on improving access to insurance by mandating that employers provide basic health insurance or pay a tax to cover enrollment in a public plan. These proposals do not directly address the problem of rising costs and may cause firms to lay off low-wage workers.
- National health insurance proposals would provide insurance for all Americans through a single national insurer. Without substantial restraints on the quality and quantity of care provided, national health insurance could lead to a cost explosion.
- Attempts to regulate the price of health care are often ineffective in reducing expenditures because of offsetting increases in utilization. If rate regulation succeeds in holding down prices, it may lead to reductions in the quality of health care and to waiting lines for services.

## CONCLUSION

The U.S. health care market provides a very high standard of health care to most Americans. The cost of care in this market has, however, been growing very rapidly, and many Americans have inadequate health insurance coverage. Careful analysis of this market indicates that it is subject to many of the same economic forces as other sectors and establishes certain guiding principles that must be heeded if reform is to be successful.

As government and employer-provided health insurance programs have expanded, Americans have been paying for less of their health care out of their own pockets. Because people with health insurance do not face the full cost of their health care decisions, they overconsume health care services. Over time, the quantity and quality of services consumed by Americans have been increasing rapidly.

Because of the high cost of health care, many of the poor and chronically ill find that they cannot afford health insurance. These uninsured individuals often resort to hospital emergency rooms, resulting in a very costly and inefficient use of resources. Most Americans believe poor and unhealthy people should not have to choose between paying high premiums for health insurance or going without any insurance at all.

Because of the complexity of the health care industry, no reform plan can address all features of the system perfectly. Yet some approaches are better than others, because they deal more directly with the sources of rising expenditures and declining insurance coverage. Successful reforms must create incentives for consumers, insurers, and providers to cut costs and share the cost of care for the chronically ill.

Experience in other countries and in the United States suggests that health care costs cannot be controlled, even with waiting lines and limits on the use of medical treatments, unless the consumption of services is limited through incentives, such as deductibles and copayments, that encourage people to regulate the way they use health care services. Alternatively, insurers can monitor the use of care through coordinated care arrangements. Failure to control the overconsumption of services that results from insurance will make it impossible to control health care costs.

Even if overall costs can be controlled, expenditures for health care are likely to remain higher for those in poor health than for healthy people. One approach to this problem, community rating, creates a single premium level for everyone. In a competitive insurance market, however, community rating conflicts with the incentives of both insurers and healthy people. Insurers will try to discourage unhealthy people from enrolling in their insurance plans, leaving the chronically ill without insurance. Alternatively, healthy people will opt out of the insurance market or select plans with high deductibles and copayments, so that the premiums paid by those remaining in more comprehensive plans are very high. Another response to differences in health risk is the use of health risk adjusters, which provide insurers with incentives to insure those in poor health.

Because providers know more about medical treatment than do patients, a successful reform must give providers financial incentives to recommend only those treatments whose benefits exceed their costs. Financing arrangements that pay doctors and hospitals a fixed amount regardless of how many services they provide reduce the incentive for providers to recommend unnecessary services. An important additional step toward achieving this goal is to make it easier for patients to evaluate health care providers. Informed patients will be better able to identify providers that offer high-quality health care at a reasonable price.

Reforms that give consumers, insurers, and providers appropriate incentives are likely to be the most effective way of controlling costs, improving access to insurance, and giving Americans the quality of health care that they want. Without these incentives, health care costs will continue to climb and the number of uninsured will only grow larger.

## 192 Special Message to the Congress Recommending a Comprehensive Health Program. *November* 19, 1945

*To the Congress of the United States:*

In my message to the Congress of September 6, 1945, there were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen.

One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of . . . sickness. . . ."

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently—in terms which all of us can understand.

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 percent of all those examined. The percentage of rejection was lower in the younger age groups, and higher in the higher age groups, reaching as high as 49 percent for registrants between the ages of 34 and 37.

In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the Armed Forces for diseases or defects which existed before induction.

Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives.

It is not so important to search the past in order to fix the blame for

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these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation—especially during the last four years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future—unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race—everywhere in the United States.

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

There are five basic problems which we must attack vigorously if we would reach the health objectives of our Economic Bill of Rights.

1. The first has to do with the number and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel—doctors, dentists, public health

and hospital administrators, nurses and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were 31 counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

The demobilization of 60,000 doctors, and of the tens of thousands of other professional personnel in the Armed Forces is now proceeding on a large scale. Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with greater financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 percent of the total in the country, with some 15,000,000 people, have either no local hospital, or none that meets even the minimum standards of national professional associations.

The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public health services and maternal and child care. The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full-time local public health service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole Nation.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and inoculation for the prevention of communicable diseases are accepted public health functions. So too are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox, and diphtheria—diseases for which there are effective controls—have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria, and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

Research—well directed and continuously supported—can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death—diseases of the heart, kidneys and arteries, rheumatism, cancer, diseases of childbirth, infancy and childhood, respiratory diseases and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year, and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coordinated research on the cause, prevention and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses. Accurate statistics are lacking, but there is no doubt that there are at least two million persons in the United States who are mentally ill, and that as many as ten million will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds, at a cost of about 500 million dollars per year—practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental-disease hospitals, more out-patient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also, we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peace-time for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

In the aggregate, all health services—from public health agencies, physicians, hospitals, dentists, nurses and laboratories—absorb only about 4 percent of the national income. We can afford to spend more for health.

But four percent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs, and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

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Each of us knows doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort, but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them. I am sure that there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day, there are about 7 million persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about 3¼ millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for six months; many of them will continue to be disabled for years, and some for the remainder of their lives.

Every year, four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work—about forty times the number of days lost because of strikes on the average during the ten years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment, and is therefore not covered by workmen's compensation laws.

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These then are the five important problems which must be solved, if we hope to attain our objective of adequate medical care, good health, and protection from the economic fears of sickness and disability.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts—each of which contributes to all the others.

### FIRST: CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health, and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have.

In carrying out this program, there should be a clear division of responsibilities between the States and the Federal Government. The States, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation, and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving state plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases—mental as well as physical—and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

## SECOND: EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-State cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services, and services for crippled children.

These programs were especially developed in the ten years before the war, and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and, in many cities, they are only partially developed.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population, and must make adequate provision for the safe birth of every baby, and for the health protection of infants and children.

Present laws relating to general public health, and to maternal and child health, have built a solid foundation of Federal cooperation with the States in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency, and has provided much-needed care. So too have other wartime programs such as venereal disease control, industrial hygiene, malaria control, tuberculosis control and other services offered in war essential communities.

The Federal Government should cooperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the States themselves, and should be administered by the States. Federal grants should be in proportion to State and local expenditures, and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education, should be recognized as a definite public responsibility.

In the conquest of many diseases prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and wide-spread health and physical education and

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examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

### THIRD: MEDICAL EDUCATION AND RESEARCH

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to non-profit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and non-profit private agencies.

In my message to the Congress of September 6, 1945, I made various recommendations for a general Federal research program. Medical research—dealing with the broad fields of physical and mental illnesses—should be made effective in part through that general program and in part through specific provisions within the scope of a national health program.

Federal aid to promote and support research in medicine, public health and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program, if it is to meet its responsibilities for high grade medical services and for continuing progress. Coordination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coordination.

## FOURTH: PREPAYMENT OF MEDICAL COSTS

Everyone should have ready access to all necessary medical, hospital and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people—sick and well—were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

During the past fifteen years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3% or 4% of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all, and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund, instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on state-by-state action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross state boundary lines.

Medical services are personal. Therefore the nation-wide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the health insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county and state general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine".

I repeat—what I am recommending is *not* socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, government employees and employees of non-profit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the States in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

Premiums for present social insurance benefits are calculated on the first $3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount such as $3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4% of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals.

We are a rich nation and can afford many things. But ill-health which can be prevented or cured is one thing we cannot afford.

### FIFTH: PROTECTION AGAINST LOSS OF WAGES FROM SICKNESS AND DISABILITY

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation, and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will of course come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and longterm disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits, rather than with services. It has to be coordinated with the other cash benefits under existing social insurance systems. Such coordination should be effected when other social security measures are reexamined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

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I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.

By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

Harry S. Truman

## 394 Remarks With President Truman at the Signing in Independence of the Medicare Bill. *July 30, 1965*

**President Truman.** Thank you very much. I am glad you like the President. I like him too. He is one of the finest men I ever ran across.

*Mr. President, Mrs. Johnson, distinguished guests:*

You have done me a great honor in coming here today, and you have made me a very, very happy man.

This is an important hour for the Nation, for those of our citizens who have completed their tour of duty and have moved to the sidelines. These are the days that we are trying to celebrate for them. These people are our prideful responsibility and they are entitled, among other benefits, to the best medical protection available.

Not one of these, our citizens, should ever be abandoned to the indignity of charity. Charity is indignity when you have to have it. But we don't want these people to have anything to do with charity and we don't want them to have any idea of hopeless despair.

Mr. President, I am glad to have lived this long and to witness today the signing of the Medicare bill which puts this Nation right where it needs to be, to be right. Your inspired leadership and a responsive forward-looking Congress have made it historically possible for this day to come about.

Thank all of you most highly for coming here. It is an honor I haven't had for, well, quite awhile, I'll say that to you, but here it is:

Ladies and gentlemen, the President of the United States.

**The President.** *President and Mrs. Truman, Secretary Celebrezze, Senator Mansfield, Senator Symington, Senator Long, Governor Hearnes, Senator Anderson and Congressman King of the Anderson-King team, Congressman Mills and Senator Long of the Mills-Long team, our beloved Vice President who worked in the vineyard many years to see this day come to pass, and all of my dear friends in the Congress—both Democrats and Republicans:*

The people of the United States love and voted for Harry Truman, not because he gave them hell—but because he gave them hope.

I believe today that all America shares my joy that he is present now when the hope that he offered becomes a reality for

**Reproduced from Remarks with President Truman at the signing in Independence of the Medicare bill. recommending a Comprehensive Health Program. In the Public papers of the Presidents of the United States: Lyndon B. Johnson, G.P.O., 1966. p. 811-815.**

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millions of our fellow citizens.

I am so proud that this has come to pass in the Johnson administration. But it was really Harry Truman of Missouri who planted the seeds of compassion and duty which have today flowered into care for the sick, and serenity for the fearful.

Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people that they touch. Few can see past the speeches and the political battles to the doctor over there that is tending the infirm, and to the hospital that is receiving those in anguish, or feel in their heart painful wrath at the injustice which denies the miracle of healing to the old and to the poor. And fewer still have the courage to stake reputation, and position, and the effort of a lifetime upon such a cause when there are so few that share it.

But it is just such men who illuminate the life and the history of a nation. And so, President Harry Truman, it is in tribute not to you, but to the America that you represent, that we have come here to pay our love and our respects to you today. For a country can be known by the quality of the men it honors. By praising you, and by carrying forward your dreams, we really reaffirm the greatness of America.

It was a generation ago that Harry Truman said, and I quote him: "Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection."

Well, today, Mr. President, and my fellow Americans, we are taking such action—20 years later. And we are doing that under the great leadership of men like John McCormack, our Speaker; Carl Albert, our majority leader; our very able and beloved majority leader of the Senate, Mike Mansfield; and distinguished Members of the Ways and Means and Finance Committees of the House and Senate—of both parties, Democratic and Republican.

Because the need for this action is plain; and it is so clear indeed that we marvel not simply at the passage of this bill, but what we marvel at is that it took so many years to pass it. And I am so glad that Aime Forand is here to see it finally passed and signed—one of the first authors.

There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

And through this new law, Mr. President, every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will help meet the fees of the doctors.

Now here is how the plan will affect you.

During your working years, the people of America—you—will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about $1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing home after a period of hospital care.

And under a separate plan, when you are 65—that the Congress originated itself, in its own good judgment—you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay $3 per month after you are 65 and your Government will contribute an equal amount.

The benefits under the law are as varied and broad as the marvelous modern medicine itself. If it has a few defects—such as the method of payment of certain specialists—then I am confident those can be quickly remedied and I hope they will be.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.

And this bill, Mr. President, is even broader than that. It will increase social security benefits for all of our older Americans. It will improve a wide range of health and medical services for Americans of all ages.

In 1935 when the man that both of us loved so much, Franklin Delano Roosevelt, signed the Social Security Act, he said it was, and I quote him, "a cornerstone in a structure which is being built but it is by no means complete."

Well, perhaps no single act in the entire administration of the beloved Franklin D. Roosevelt really did more to win him the illustrious place in history that he has as did the laying of that cornerstone. And I am so happy that his oldest son Jimmy could be here to share with us the joy that is ours today. And those who share this day will also be remembered for making the most important addition to that structure, and you are making it in this bill, the most important addition that has been made in three decades.

History shapes men, but it is a necessary faith of leadership that men can help shape history. There are many who led us to this historic day. Not out of courtesy or deference, but from the gratitude and remembrance which is our country's debt, if I may be pardoned for taking a moment, I want to call a part of the honor roll: it is the able leadership in both Houses of the Congress.

Congressman Celler, Chairman of the Judiciary Committee, introduced the hospital insurance in 1952. Aime Forand from Rhode Island, then Congressman, introduced it in the House. Senator Clinton Anderson from New Mexico fought for Medicare through the years in the Senate. Congressman Cecil King of California carried on the battle in the House. The legislative genius of the Chairman of the Ways and Means Committee, Congressman Wilbur Mills, and the effective and able work of Senator Russell Long, together transformed this desire into victory.

And those devoted public servants, former Secretary, Senator Ribicoff; present Secretary, Tony Celebrezze; Under Secretary Wilbur Cohen; the Democratic whip of the House, Hale Boggs on the Ways and Means Committee; and really the White House's best legislator, Larry O'Brien, gave not just endless days and months and, yes, years of patience—but they gave their hearts—to passing this bill.

Let us also remember those who sadly

cannot share this time for triumph. For it is their triumph too. It is the victory of great Members of Congress that are not with us, like John Dingell, Sr., and Robert Wagner, late a Member of the Senate, and James Murray of Montana.

And there is also John Fitzgerald Kennedy, who fought in the Senate and took his case to the people, and never yielded in pursuit, but was not spared to see the final concourse of the forces that he had helped to loose.

But it all started really with the man from Independence. And so, as it is fitting that we should, we have come back here to his home to complete what he began.

President Harry Truman, as any President must, made many decisions of great moment; although he always made them frankly and with a courage and a clarity that few men have ever shared. The immense and the intricate questions of freedom and survival were caught up many times in the web of Harry Truman's judgment. And this is in the tradition of leadership.

But there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.

I said to Senator Smathers, the whip of the Democrats in the Senate, who worked with us in the Finance Committee on this legislation—I said, the highest traditions of the medical profession are really directed to the ends that we are trying to serve. And it was only yesterday, at the request of some of my friends, I met with the leaders of the American Medical Association to seek their assistance in advancing the cause of one of the greatest professions of all—the medical profession—in helping us to maintain and to improve the health of all Americans.

And this is not just our tradition—or the tradition of the Democratic Party—or even the tradition of the Nation. It is as old as the day it was first commanded: "Thou shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land."

And just think, Mr. President, because of this document—and the long years of struggle which so many have put into creating it—in this town, and a thousand other towns like it, there are men and women in pain who will now find ease. There are those, alone in suffering, who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing poverty—despite their long years of labor and expectation—who will now look up to see the light of hope and realization.

There just can be no satisfaction, nor any act of leadership, that gives greater satisfaction than this.

And perhaps you alone, President Truman, perhaps you alone can fully know just how grateful I am for this day.

NOTE: The President spoke at 2:55 p.m. in the auditorium of the Harry S. Truman Library in Independence, Mo. In his opening words he referred to former President and Mrs. Harry S. Truman, Secretary of Health, Education, and Welfare Anthony J. Celebrezze, Senator Mike Mansfield of Montana, majority leader of the Senate, Senator Stuart Symington and Senator Edward V. Long of Missouri, Governor Warren E. Hearnes of Missouri, Senator Clinton P. Anderson of New Mexico, Representative Cecil R. King of California, Representative Wilbur D. Mills of Arkansas, Senator Russell B. Long of Louisiana, and Vice President Hubert H. Humphrey.

During his remarks the President referred to, among others, Representative John W. McCormack of Massachusetts, Speaker of the House of Representatives, Representative Carl Albert of Oklahoma, majority leader of the House of Representatives, Aime Forand, Representative from Rhode Island 1937–1939 and 1941–1961, Representative Emanuel Celler of New York, Senator Abraham Ribicoff of

Connecticut, former Secretary of Health, Education, and Welfare, Under Secretary of Health, Education, and Welfare Wilbur J. Cohen, Representative Hale Boggs of Louisiana, Lawrence F. O'Brien, Special Assistant to the President, John D. Dingell, Representative from Michigan 1933–1955, Robert F. Wagner, Senator from New York 1927–1949, James E. Murray, Senator from Montana 1934–1961, and Senator George A. Smathers of Florida.

As enacted, the Medicare bill (H.R. 6675) is Public Law 89–97 (79 Stat. 286).

On July 25, 1965, the White House released a report to the President from Secretary Celebrezze in response to the President's request for organizational changes in the Social Security Administration in preparation for administering the Medicare program.

The report stated that the reorganization would accomplish the following major purposes:

"It establishes new units in the Administration with special responsibility for hospital and supplementary medical insurance programs;

"It changes some existing units, giving them additional responsibilities under new programs;

"It centers data processing and transmission activities in a central headquarters in the Administration;

"It strengthens upper-level management in the Administration, makes the field service of the Administration more responsive to directions from headquarters, and improves coordination between Administration units."

The text of Secretary Celebrezze's report is printed in the Weekly Compilation of Presidential Documents (vol. 1, p. 6).

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**Congressional Clearinghouse on the Future**

# DIALOGUES ON AMERICA'S FUTURE

with

## C. Everett Koop, M.D.

I guess if I wanted to give you a Surgeon General's title for my remarks today it could be the 'American Health Care System Could Be Dangerous to Your Health.'

My views are based on more than a half-a-century of medicine. The most important of those years, the last two and one half years, I have been crisscrossing this country looking at where we have been and where we are going — and perhaps where we should go. I must say that these problems are not new, and they have been around ever since I came into government in 1981 and before that. I think it is clear that politicians dawdled until the crisis deepened, and I think it is actually the American people who have shamed them into action.

There are three basic incompatible demands I think Americans have for their health care system:

1. We demand easy access to health care.
2. We want the highest high-tech medicine.
3. We want it at a limited cost.

You cannot have all three of those together. You can have any two at one time, but I don't think you can have all three.

To begin with, I think our big problem is that we have very high expectations as a society from health and from medicine. We put a great deal of faith in new procedures and surgery, new pharmaceuticals, and new technologies of all kinds. We still have a lot of faith in what I call the 'magic of medicine'. We routinely expect miracles to happen, even when in the real world, the medical profession is not able to deliver. It has also become equally clear in recent years that those high expectations are fast outrunning our ability to pay for them. Our health care system, may function with compassion, with competence, at times with excellence, but not for enough Americans. For too many of your fellow citizens, the health-care system in this country operates as a tyranny. For them it is more a curse than it is a blessing.

I think there is something terribly wrong with a health-care system — or perhaps you should call it a non-system — that spends more and more money to provide less and less service for fewer and fewer people each year. But that is a very apt, true description of what has happened to health care, especially in the last decade and a half.

Like many of our national problems, this crisis is a very complicated one, and it will require a variety of solutions.

They will have to be in part Federal, regional, and local. They will have to be public as well as private, and they will also have to be personal. It is my absolute conviction that there is no panacea for the situation we find ourselves in — there is no single magic bullet, no easy answers, only a series of very hard choices. We have to reform very wisely or we could find one of two things happening: either monolithic government medicine or private medicine run amok . Now each of those is exorbitantly expensive, and neither one of them is sensitive to patients needs.

If everyone that was interested in health-care reform was a person of goodwill (which he is not), and if all the people with a plan could decide on one plan (which they cannot), and everything went as smoothly as it possibly could (which you know it will not), it will take us a year to get from where we are to where we ought to be in health-care reform. I think that is something the Congress doesn't seem to understand; I don't think either presidential candidate understands. One of the things that frightens the life out of me is to read that Governor Clinton plans in the first 100 days to push a package in the Congress that will solve all of our health-care problems. My fear is that, with 741 health-care lobbies, a package will become so encrusted with barnacles that by the time it goes through Congress, you might get either one of these things I mentioned. It would not surprise me to see something happen such as happened to catastrophic insurance in the Reagan term: a decent bill came forward, but by the time it was massaged, it was so encumbered that it was not possible to fund it three years down the road.

Usually debates about the health-care crisis center very much around economics, but I would like to ask you to consider whether or not they are not ethical as well. I think it would be much easier to enact rather sweeping reforms if the American people could agree on basic values and ethics upon which the health-care system and, indeed, our whole society is based. If we could reach an ethical consensus, a lot of economic and political barriers to success could be easily solved.

You know that there are many factors that drive up the cost of health care. I think the most important of them is the demand by every hospital in the land to have absolute state-of-the-art technology. Society demands that they have this. And hospitals copy each other so that they can turn a profit. Physicians fees have soared in the past to astronomical levels. Wages for other health-care workers are escalating; buildings need replacement; much equipment is now obsolete; prices are raised for privately insured patients in order to cover the cost for those who have no insurance; and we have a unique situation where new technology does not supplant old technology, it merely compliments it. If any of you have anything to do with imaging, you know that 10 years ago CAT scans were all the rage. Then we got MRIs, and you would think MRIs would just put CAT scans right off the map. That is not true. Now patients get both a CAT scan and a MRI — $600 plus $1,200 and the cost of medical care continues to soar.

**Competition.** I hope you all know that competition in health care increases costs. If you have a new mechanic who is great with automobile valves move into your town, the cost of a valve job on your car will eventually come down, and probably quality will go up. But if a new cardiovascular surgeon comes to your town, the cost of a valve job on your heart will go up without any guarantee that the quality will follow. It is not like buying and selling television sets because medicine's competition is based on service and not on price.

To get back to why our prices are out-of-control — pharmaceuticals are extremely high priced as is everything in medicine. Most of the things you get in a hospital today are disposable. In our society, we equate throw-away with low cost, and that is absolutely not the case.

We have a very unique problem in America: the expense of defensive medicine. We have to cover the very litigious society we have today that tends to sue when any encounter with the medical profession is not perfection itself. Those things are enough to smother any system.

**Coverage**. But we have two problems that are not unique to us, the whole world faces them:

1. The emerging aging population with health-care costs per capita that are eight times more than they are for people under the age of 65.

2. AIDS. No one knows the limits of the AIDS epidemic. We have already seen the cost go from hundreds of thousands to hundreds of millions, and now we are up in the billions. And there is no end in sight.

The disruption caused by the present system is unconscionable. Millions of Americans live in a special kind of fear that they are only an illness or an accident away from financial disaster. I am sure that you know each year thousands upon thousands of Americans are literally impoverished by our health-care system.

**If I were to summarize what I have been trying to say, it is this: we have a health-care system with almost no self-regulation on the part of those who provide that care, namely hospitals and physicians. The system is devoid of the natural market place controls that competition should bring, whether we are talking about price, or quality, or service. Efforts so far have been to contain costs, and I think that focusing attention on containing costs is like squeezing a balloon on the bottom — but it bulges up somewhere else. Around the country some cost containment policies have actually made health care even worse.**

**Insurance.** No doubt about the fact that our insurance system is a scandalous thing. It operates like a shell game in many parts of the country. We end up by having 35 to 37 million of our fellow Americans either uninsured or uninsurable or only seasonally insured. At certain times of the year, they have no coverage at all. The two other things that are very important for the insurance system to recognize are "job-lock", where you can't leave because if you do you lose your insurance, and the other is that many people cannot get insurance because they have "pre-existing conditions." For this group of about two and one-half million Americans, the plight of being uninsurable is really extraordinarily unreasonable. We have to bring insurance companies — if needed by Congressional mandate — into a position where instead of making their money on the basis of how well they can cherry pick (pick out communities and individuals with high risk), they have to be forced to have pools sufficiently large so that health care becomes available and affordable to every single American.

We have to replace the regressive employer tax exceptions exemptions for insurance with tax credits or vouchers that link individual insurance coverage with one's ability to pay. That is certainly something that could replace Medicare. One of the things I think bothers most Americans I talk to is that 26 cents out of every insurance dollar is spent on administration. There are 1160 insurance forms that physicians use. They can be replaced by Congress tomorrow by mandate, with one form, or perhaps you want to be very generous and have three, that cover most situations very well. But the long term goal could be to get rid of paper entirely and report insurance claims and medical records electronically so that if you are in Des Moines, Iowa, or Portland, Maine, your medical record is available to the physician at the push of a button.

The way doctors offices' function these days is one of the most daunting things about medical practice. I have been spending a lot of time in New Hampshire lately, and in New Hampshire, it is not easy to make money as a generalist. The population is rural, widely separated, and some parts of it not economically well-off. Physicians are quitting. The reason they are quitting has nothing to do with patients; it has to do with the overburdening paper work they have to do. There is no doubt about the fact that a doctor's office spends more time on the paper work for a given patient than that physician does looking after the patient.

**Poverty.** Now you cannot talk about illness and health unless you recognize that we treat diseases of the body but there are some diseases which stem from society. In this rich country, the number one disease is the shameful prevalence of poverty. It lies at the root of most of our public health problems. I give you an example: When I was Surgeon General, and I was hitting my head against the wall about many things, whether it was drug abuse, AIDS, alcohol abuse, malnutrition, smoking or lack of immunization, it was fundamentally poverty that made these problems what they are. And the discouraging statistics that we have in public health, such as high infant mortality, really come from the impoverished millions of our citizens who exist on the very fringes of a otherwise affluent society.

**Health.** We must not mistake health care for health because they are not identical. It may come as a surprise to you that I think that although that is true and many Americans have too little health care, **the real problem in America is that too many people have too much health care. Health care is our costliest national enterprise, this year estimated to be in excess of $800 billion. The reason this is the case is that we do not know what works and what does not work in the theory and the practice of medicine. And further, doctors make their decisions on the value systems that they enjoy or that the profession has dictated rather than on the value systems of the public.**

Let me tell you what I mean. If somebody is 60 years old and gets up at night, three times to use the bathroom, sits on the aisle in the movies or an airplane because he has to go the John frequently, he probably has benign prostatic hyperplasia and eventually will end up in the hands of a urologist. It is now uncommon today for such a urologist to put his arm around this guy and say, "Harry, I will bring you to the hospital Thursday afternoon. We will cystoscope you. I'll take a little of your prostate, open your urethra, and you will be as good as new." He might even tell Harry what some of the risks are. That is not truly informed consent. That is getting the patient to sign onto what you have already decided to do with the patient.

I think what you ought to do is to say, "Harry, you have a benign disease that is never going to kill you. There are five ways you can treat it. Let me outline them for you and tell you what the risks and the benefits are. You decide with me what you want to do. One, we can open your belly, open your bladder, take out your prostrate, and throw it away. Two, we can do a cystoscope procedure and take out a little prostrate. Three, we have balloons we can put in the urethra and just blow them up, dilate the urethra, push back the prostrate, and that will last for 6 to 8 years. Four, there are two new drugs that shrink the prostrate. Fifth choice is do nothing and continue getting up at night. Let me tell you what the risks are. You might be incontinent; you might be impotent, you might have a hemorrhage; you might die." When you put all that on the table, it is fascinating that patients chose low-tech, low-cost health care.

In four communities, where my Dartmouth colleagues have gotten all the urologists to do this — not by asking them to do it the same way — but by putting an interactive video disk before the patient. Everybody gets exactly the same advice and exactly the same ability to ask the same questions. The costs of prostatic care dropped in those four cities 40 to 45 percent. That is what I mean about knowing what works and what does not work. That is "outcomes research."

**Outcomes research.** My idea is that we make insurance companies give us one-quarter of one cent on every dollar they take in to fund outcomes research in this country. If we did that, in ten years, we would know what worked and what did not. Then when someone in this room had to have a breast procedure done, she would know the batting averages of every hospital in the community and the batting averages of every doctor. Outcomes research is the buzz word for the rest of this decade. If you can make it mandatory, we would have a health care system where we would practice medicine on the basis on what works and what does not work.

Outcomes research also tells you about tremendous variations. To give you an example, in Boston today the number of hospital beds utilized and the cost per capita is almost twice what it is in New Haven, Connecticut, which is just a little way down the Atlantic coast. Now there is no evidence that the people in Boston are twice as sick or need twice as many hospital beds or are twice as well afterward or are twice as happy about what happened to them. The bottom line is: if you could shift the New Haven system to Boston, the annual savings in excess of hospital beds alone would be $300 million. Now just think how many cities around the country could save $300 million — and what $300 million and $300 million and $300 million would add up to. While I am on that subject, let me tell you what the buzzword for that is "reallocation of resources."

Everyone hears about the Oregon health plan. Oregon is rationing health care. I have defended Oregon in saying, there is nothing new about that, we are all rationing health care. But Oregon actually decided to ration health care only to the poor. Oregon has the second highest Medicaid administrative costs in the country. My Dartmouth colleagues, with Oregon's permission, went in and studied the situation. **They found that if they cut down their empty hospital beds, put their extra CAT scan or extra MRIs into disuse, and reallocated their resources, they could have given every poor person in the state of Oregon a full package of health care.** If you are thinking about rationing as the answer to our problems, be sure that you don't do that until you look at how you can reallocate your resources.

**Change.** In the reform of the Federal health-care system several things have to happen at the same time. It is like a football game: when the ball is snapped if everybody does not react at the same time, the play is a flop. Today we are in a situation that sounds like the last minutes of the last quarter of a losing game. Everybody in the huddle is shouting what the play should be, and there is only on person who could call that play, the coach. We don't have a coach. We need a coach, and I think the coach has to be the President.

I want to tell you very honestly that I outlined a plan for Mr. Bush after he was nominated and before he was elected on the 14 August 1988, which, had he undertaken, would have resulted in no health-care crisis at all at the present time. It still is not too late to do it, and I'll tell you what I told him. (I wrote it up later in *NewsWeek*) I have tried to get it across to Mr. Clinton. It is simply this — and I know as soon as you hear me saying a few words, you will say, oh, no, not that again — we need the bluest of blue ribbon commissions to solve this problem. It should have on it, doctors, lawyers, administrators, statesmen, but the most important thing is Republican and Democratic Congresspersons and Senators, who, by accepting the position on the commission would agree to attend all the meetings themselves and not send their staff as substitutes.

Now what that does is enable those people to become knowledgeable. They would expound a cause, and they are the only people who can take a plan from a commission back to the floors of Congress where they can lead the debate and where something will come about. That is how this country got social security. I know this President hates commissions. I know many people hate commissions, but this one would work.

The great advantage of doing it now, is that it buys time, and it prevents the scramble that I think is going to take place no matter who is president. It avoids the business of all those barnacles on a bill that might of itself be good, but would be so encumbered that it becomes impossible legislation. The other thing to do is, instead of sitting down at the table the first day and deciding on the agenda for the next year, as commissions tend to do, you could give them their homework already done for them. Present them with 14, or 15, or 17, or 9 white papers which are the only possible answers to the dilemmas we face. Two weekends of heavy reading could put them in the position to start to act.

I have been interest in health care reform for 25 years. I have been especially interested in health care reform ever since I entered government as your Surgeon General.

I have gotten very discouraged about doing anything about it because no matter what administration is in power it seems to be paralyzed, our Congress seems to be paralyzed, and nothing seems to happen. It is a very daunting task when you think about what has to happen: you have to revise Medicare and Medicaid; you have to do something about the unwarranted freedom of the insurance industry; you have to do something about malpractice reform because this legalistic society makes it impossible for medicine to function the way it should; and then you have all the problems of fraud, waste and abuse. And let me say parenthetically, any health-care reform that does not address fraud, waste and abuse is not going to go over big with the American people because they see it as a very corrupt system, not just doctors, but hospitals, and politicians who have made it that way.

I am delighted that the health-care crisis has worked its way to the top of the national agenda. It is about time.

# Health Care in Rural America

## SUMMARY

Reproduced from Health Care in Rural America: summary. Washington, Office of Technology Assessment, 1990. 26 p.

CONGRESS OF THE UNITED STATES
OFFICE OF TECHNOLOGY ASSESSMENT

## Office of Technology Assessment

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The Technology Assessment Board approves the release of this report. The views expressed in this report are not necessarily those of the Board, OTA Advisory Council, or individual members thereof.

**ABOUT THE COVER:**
Population density map of the Unites States (one dot equals 1,000 people).
Black areas represent areas of relatively low population density.

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# Foreword

Federal policies to advance the Nation's health have often included provisions to mitigate the special problems in delivering health care in rural areas. Recently, however, these policies have received renewed scrutiny in the face of reported increases in rural hospital closures, ongoing problems in recruiting and retaining health personnel, and difficulty in providing medical technologies commonly available in urban areas. Mounting concerns related to rural residents' access to health care prompted the Senate Rural Health Caucus to request that OTA conduct an assessment of these and related issues. This report, *Health Care in Rural America*, is the final product of that assessment. (Two other OTA papers, *Rural Emergency Medical Services* and *Defining "Rural" Areas: Impact on Health Care Policy and Research*, have previously been published in connection with this assessment.)

An advisory panel, chaired by Dr. James Bernstein of the North Carolina Office of Rural Health and Resource Development, provided guidance and assistance during the assessment. Also, three public meetings were held (in Scottsdale, Arizona; Bismarck, North Dakota; and Meridian, Mississippi) to provide OTA with the opportunity to discuss specific rural health topics with local and regional health practitioners, administrators, and officials. Site visits to local facilities were conducted in association with these activities. A number of individuals from both government and the private sector provided information and reviewed drafts of the report.

OTA gratefully acknowledges the contribution of each of these individuals. As with all OTA reports, the content of the assessment is the sole responsibility of OTA and does not necessarily constitute the consensus or endorsement of the advisory panel or the Technology Assessment Board. Key staff responsible for the assessment were Elaine Power, Lawrence Miike, Maria Hewitt, Tim Henderson, Leah Wolfe, Marc Zimmerman, and Rita Hughes.

John H Gibbons

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NOTE: OTA appreciates and is grateful for the valuable assistance and thoughtful critiques provided by the advisory panel members. The panel does not, however, necessarily approve, disapprove, or endorse this report. OTA assumes full responsibility for the report and the accuracy of its contents.

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[1] From May 1989.
[2] Until May 1989.
[3] Until August 1989.
[4] From June 1989.
[5] From June 1990.
[6] Until June 1989.

## Glossary of Abbreviations

AAFP —American Academy of Family Physicians
AANP —American Academy of Nurse Practitioners
AAPA —American Academy of Physician Assistants
ACNM —American College of Nurse-Midwives
ACOG —American College of Obstetricians and Gynecologists
ADAMHA —Alcohol, Drug Abuse, and Mental Health Administration (PHS)
ADMS —Alcohol, Drug Abuse, and Mental Health Services Block Grant
AFDC —Aid to Families with Dependent Children
AHA —American Hospital Association
AHCPR —Agency for Health Care Policy and Research (PHS)
AHEC —area health education center
AHP —allied health professional
AMA —American Medical Association
AOA —American Optometric Association
ASC —ambulatory surgery center
BHCDA —Bureau of Health Care Delivery and Assistance (HRSA, PHS)
BHPr —Bureau of Health Professions (HRSA, PHS)
BLS —Bureau of Labor Statistics (Department of Labor)
CCEC —Community Clinic/Emergency Center
CDC —Centers for Disease Control (PHS)
CFR —Code of Federal Regulations
CHC —community health center
CHMSA —Critical Health Manpower Shortage Area
CLT —clinical laboratory technician/technologist
CMHC —community mental health center
C/MHC —community/migrant health center
CNM —certified nurse-midwife
COBRA —Consolidated Omnibus Budget Reconciliation Act of 1985
COGME —Council on Graduate Medical Education
CON —certificate of need
CRNA —certified registered nurse anesthetist
CT —computed tomography
DEFRA —Deficit Reduction Act of 1984
DHEW —Department of Health, Education, and Welfare (now DHHS)
DHHS —Department of Health and Human Services
DO —doctor of osteopathy
DRGs —diagnosis-related groups
EACH —Essential Access Community Hospital
ECH —Emergency Care Hospital
EMT —emergency medical technician
EPSDT —Early and Periodic Screening, Diagnosis, and Treatment (Medicaid)
ESWL —extracorporeal shock wave lithotripsy
FMG —foreign medical graduate
FmHA —Farmers Home Administration (USDA)
FNP —family nurse practitioner
FP —family practitioner
FR —Federal Register
FTC —Federal Trade Commission
FTCA —Federal Tort Claims Act
FTE —full-time equivalent
FY —Federal fiscal year
GAO —General Accounting Office (U.S. Congress)
G/FP —general/family practitioner
GME —graduate medical education
GMENAC —Graduate Medical Education National Advisory Committee
GP —general practitioner
GPCI —Geographic Practice Cost Index
HCFA —Health Care Financing Administration (DHHS)
HHI —Herfindahl-Hirschman Index
HMO —health maintenance organization
HMSA —Health Manpower Shortage Area
HPOL —HMSA Placement Opportunity List
HRSA —Health Resources and Services Administration (PHS)
HUD —U.S. Department of Housing and Urban Development
IMU —Index of Medical Underservice
IOM —Institute of Medicine
IRS —Internal Revenue Service
JCAHO —Joint Commission on the Accreditation of Healthcare Organizations
LHD —local health department
LP/VN —licensed practical/vocational nurse
MAF —Medical Assistance Facility
MD —medical doctor
MHC —migrant health center
MHREF —Montana Hospital Research and Education Foundation
MHS —multihospital system
MLP —midlevel practitioner
MPCA —Michigan Primary Care Association
MRI —magnetic resonance imaging
MSA —metropolitan statistical area
MUA —Medically Underserved Area
MUA/P —Medically Underserved Area/Population
MUP —Medically Underserved Population
NGA —National Governors' Association
NHSC —National Health Service Corps (BHCDA, HRSA, PHS)
NIMH —National Institute of Mental Health (ADAMHA, PHS)
NLM —National Library of Medicine
NP —nurse practitioner
NRHA —National Rural Health Association
OB/GYN —obstetrician/gynecologist
OBRA —Omnibus Budget Reconciliation Act
OMB —U.S. Office of Management and Budget
ORH —office of rural health (State-level)
ORHP —Office of Rural Health Policy (HRSA, PHS)
OT —occupational therapist
OTA —Office of Technology Assessment (U.S. Congress)
PA —physician assistant
PCCA —primary care cooperative agreement
PHHS —Preventive Health and Health Services Block Grant

PHS —Public Health Service (DHHS)
PPA —private practice assignment
PPO —private practice option
PPRC —Physician Payment Review Commission
PPS —prospective payment system (Medicare)
PRO —peer review organization
ProPAC —Prospective Payment Assessment Commission
PT —physical therapist
RBRVS —resource-based relative value scale (Medicare)
RHC —rural health clinic (Medicare/Medicaid-certified)
RN —registered nurse
RPCH —Rural Primary Care Hospital
RRC —rural referral center (Medicare-certified)
RT —respiratory therapist
SCH —Sole Community Hospital (Medicare-certified)
SDMIX —South Dakota Medical Information Exchange
SIDS —sudden infant death syndrome
SNF —skilled nursing facility
SOBRA —Sixth Omnibus Budget Reconciliation Act of 1986
SSI —Supplemental Security Income
U.S.C. —United States Code
USDA —United States Department of Agriculture
WAMI —Washington, Alaska, Montana, and Idaho

## Related OTA Reports

- **Defining Rural Areas: Impact on Health Care Policy and Research—Staff Paper.** Examines and identifies health service needs of rural subpopulations. 7/89; 68 p.
  GPO stock #052-003-01156-5; $3.25
  NTIS order #PB 89-224 646

- **Rural Emergency Medical Services—Special Report.** Describes the availability and distribution of emergency medical service resources, and examines how limited Federal resources can be used to improve rural EMS. H-445, 11/89; 108 p.
  GPO stock #052-003-01173-5; $4.75
  NTIS order #PB 90-159 047/AS

- **Indian Health Care.** Analyzes the quality and adequacy of data on Indian health status; identifies the types and distribution of technologies and services available through the Indian Health Service and other providers; determines the desirable range and methods of delivery of health-related technologies and services; and develops policy options to improve the selection, provision, financing, and delivery of technologies and services; and develops policy options to improve the selection, provision, financing, and delivery of technologies and services to Indian populations. H-290, 4/86; 384 p.
  NTIS order #PB 86-206 091/AS

- **Indian Adolescent Mental Health—Special Report.** Evaluates the mental health needs of American Indian and Alaska Native adolescents. H-446, 1/90; 92 p.
  GPO stock #052-003-01175-1; $3.50

- **Technology, Public Policy, and the Changing Structure of American Agriculture.** Focuses on future and emerging technologies in animal, plant, chemical, mechanization, and information areas and their implications for agricultural structure. Also explores linkages between policy and structure for a clearer understanding of the factors that influence the evolution of the agriculture sector. F-285, 3/86; 380 p.
  NTIS order #PB 86-184 637/AS

- **Information Age Technology and Rural Economic Development.** In order to identify economic opportunities and problems for rural communities made possible by information technologies, the study will: 1) describe the status of rural America in the information age; 2) assess the current relevant communications technologies and services; 3) analyze current public sector actions; 4) evaluate emerging communications technologies and services; 5) describe the ways in which communications technologies may affect rural development; 6) assess the barriers to technological improvements in rural areas; 7) determine whether technology can foster a new era of economic opportunity in rural areas. F-285, 3/86; 380 p.
  NTIS order #PB 86-184 637/AS

NOTE: Reports are available from the U.S. Government Printing Office, Superintendent of Documents, Washington, DC 20402-9325 (202) 783-3238, and the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161-0001 (703) 487-4650.

# Summary and Options

## INTRODUCTION AND SCOPE

This report is about access of people in rural America to basic health care services.

The 1980s witnessed rural economic decline and instability, major changes in Federal health programs, and increasing concern about the long-term viability of the rural health care system. This concern prompted the Senate Rural Health Caucus and the Ranking Minority Member of the Senate Committee on Labor and Human Resources to request that OTA assess the availability of health services in rural communities, the problems rural providers face, and the remedial strategies that might be influenced by Federal policy.[1]

This report focuses on trends in the availability of primary and acute health care in rural areas and factors affecting those trends.[2] The rest of this summary presents OTA's findings and conclusions on rural health care availability and options for congressional consideration. Many of these options bear some similarity to proposals by others to improve rural health care services, although the details may differ considerably. The report itself examines in detail the issues faced by rural facilities providing health services and by physicians and other rural health personnel. To provide examples of how these issues may play out, it also discusses in more depth two specific groups of services: maternal and infant health services and mental health services.

Although the affordability of health care is an important factor in access to care by rural residents, the fundamental issue of uninsured populations and uncompensated care is beyond the scope of this report, since it encompasses the urban as well as the rural health care system and has broad ramifications. Moreover, even if it were possible to enable all patients to adequately compensate providers, policymakers would still find it necessary to consider measures to overcome the special access problems of underserved areas and populations. Thus, the report does not discuss in depth either health insurance coverage or health care financing. Instead, it considers these factors in terms of their influence on the availability and financial viability of providers.

Two other important issues are also beyond the scope of this report. First, the importance of rural health care providers as sources of employment and income is not addressed here, although it is a vital issue in many rural communities. Second, this report does not examine the quality of rural health care in any detail, although it is clear that the quality implications of rural health interventions deserve scrutiny. But such an examination would have to proceed with care. By necessity, an evaluation of the quality of a service provided in rural areas must be measured against the implications of having no locally available service at all.

## PROBLEMS AND CONSIDERATIONS IN RURAL HEALTH CARE

### *The Health and Health Care Access of Rural Residents*

During this century, the rural population has become an increasingly smaller proportion of the total U.S. population (figure 1). As of 1988, about 23 percent of the U.S. population lived in nonmetropolitan (nonmetro) counties (*24*). About 27 percent of the U.S. population lives in "rural" areas as defined by the Census Bureau (places of 2,500 or fewer residents) (*25*), and slightly more than 15 percent of the population is rural by both definitions.[3] **Throughout this report, "rural" refers to nonmetro areas unless otherwise stated.**

*Rural residents are characterized by relatively low mortality but relatively high rates of chronic disease.* After accounting for expected differences

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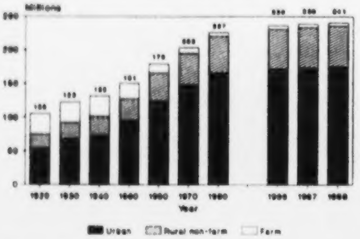
[1] Two other reports prepared in connection with this assessment have already been published: *Defining "Rural" Areas: Impact on Health Care Policy and Research* (released July 1989), and *Rural Emergency Medical Services* (released November 1989).

[2] The report does not examine issues relating to the Indian Health Service (IHS) or health-care access for Native Americans who receive their care from the IHS. Previously published OTA reports examined these issues in detail (*18,19*).

[3] See the related OTA staff paper for a detailed discussion of the implications of different definitions of "rural" and the applications of these definitions (*8*).

**Figure 1—U.S. Rural and Rural Farm Population, Selected Years, 1920-88**



[a]Based on the Census Bureau's definition of the rural population.

[b]The rural population figures from 1950 on reflect definitional changes. Had the previous definition been used, the 1950 rural population would have been 60,948,000, or 40 percent of the total U.S. population.

SOURCE: Office of Technology Assessment, 1990. Data from U.S. Department of Commerce, Bureau of the Census, jointly with the U.S. Department of Agriculture, "Rural and Rural Farm Population: 1988," *Current Population Reports*, Series P-20, No. 439 (Washington, DC: U.S. Government Printing Office, September 1989).

due to age, race, and sex distributions between urban and rural areas, mortality rates in rural areas are 4 percent lower than in urban areas (*21*). Two notable exceptions exist: in rural areas, infant mortality is slightly higher (10.8 *v.* 10.4 per 1,000 infants), and injury-related mortality is dramatically higher (0.6 *v.* 0.4 per 1,000 residents). Chronic illness and disability, on the other hand, affect a greater proportion of the rural than the urban population (14 *v.* 12 percent) (*29*).[4] There is little overall difference between urban and rural residents in rates of acute illness.

Rural populations are unique in the extent of physical barriers they may encounter when obtaining health care. Even in relatively well-populated rural areas, the lack of a public transportation system and the existence of few local providers to choose from can make it difficult for many rural residents to reach facilities where they can receive care. *And persons living in low-density "frontier" counties—counties of six or fewer persons per square mile—can have geographic access problems of immense proportions.* In these counties, predominantly located in the West, there is insufficient population density in many areas to adequately support local health services.

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*Photo credit: Peter Beeson*

Farming communities were especially hard-hit by economic slowdowns during the early 1980s.

*Economic barriers prevent many rural residents from receiving adequate health care and often outweigh strictly physical barriers.* Rural residents have lower average incomes and higher poverty rates than do urban residents, and one out of every six rural families lived in poverty in 1987 (*23*). While some rural areas have prospered (e.g., areas that have become retirement havens), areas whose economies are based on farming and mining suffered real decreases in per capita income during the first half of the 1980s (*5*). Still other rural areas have been pockets of poverty for decades. These areas of persistent poverty are heavily concentrated in the South, where 25 million of the Nation's 57 million rural residents live, and where 4 out of every 10 rural residents are poor, elderly, or both (*26*).

*Rural residents are much more likely than urban residents to have no health insurance coverage (18.2*

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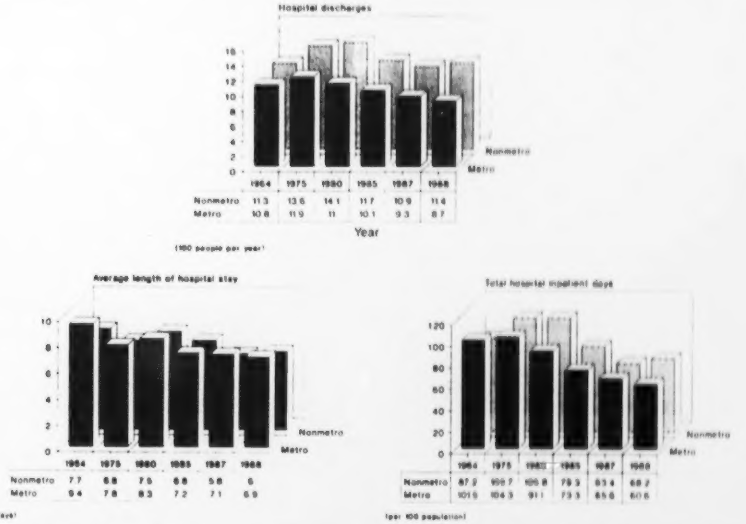
[4] These figures are age-adjusted and therefore cannot be explained by a greater proportion of elderly residents in rural areas.

**Figure 2—Trends in Hospital Utilization by Metropolitan and Nonmetropolitan Residents, Selected Years, 1964-88**



NOTE: Numbers are adjusted for age (i.e., account for differences in age distributions between metro and nonmetro areas). These data are based on interviews and thus include only patients who were discharged alive.

SOURCE: Office of Technology Assessment, 1990. Data from U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics, *Health, United States, 1982, 1988, and 1989* (Washington, DC: U.S. Government Printing Office, March 1983, March 1988, and March 1989).

v. 14.5 in 1986) (*29*).[5] Among persons with incomes below the Federal poverty level, rural residents are less likely than urban residents to be covered by Medicaid (35.5 *v.* 44.4 percent in 1987) (*15*).

Health care utilization trends in rural areas have paralleled those in urban areas. Over time, people in both areas have increased the number of physician visits per person, although rural physician utilization remains below that for urban residents. Hospital inpatient utilization by both urban and rural residents has declined (figure 2). Rural residents, however, still report more admissions and shorter hospital stays than do urban residents (*29*).[6]

### *The Availability of Rural Health Care*

Rural health care availability in 1990 is better in many ways than that of 20 years ago. After years of hospital construction, the ratio of community hospital beds to population is now about the same in rural as in urban areas (4.0 and 4.1 per 1,000 residents, respectively, in 1986). Federally funded community

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[5] Includes only persons under age 65.

[6] Information on average length of hospital stay (ALOS) is available both from hospital reports (which include patients discharged dead) and from patient interviews. Until very recently, both ALOS in rural hospitals and ALOS reported by rural residents were lower than for their urban counterparts. Since 1987, rural hospitals have actually reported slightly higher ALOS than urban hospitals, although rural residents still report lower ALOS in interview data.

*Photo credit: Peter Beeson*

Not all rural hospitals that have closed in recent years have been small. Memorial General Hospital, a 256-bed facility in Elkins, West Virginia, closed in the mid-1980s.

and migrant health centers (C/MHCs) provide subsidized care to poor residents through nearly 800 service sites in rural communities. Physician supply has been increasing for many years in both rural and urban areas; one out of every 440 people in the United States is now a physician.[7]

Nonetheless, the future prospect for rural health care in the absence of intervention is grim. *Rural America cannot support its present complement of hospitals, and the hospitals are going broke.* By 1987, rural hospitals as a group had higher expenses than patient care revenues, and small rural hospitals had higher expenses than revenues from all sources. Hospitals faced with continuing financial difficulties and no alternative forms of survival will continue to close, including some facilities that are the only reasonable source of care in their communities. Rather than drawing local patients back to local care, many small community facilities will continue to lose wealthier patients to more distant urban hospitals and clinics. Local facilities will be left to contend with low occupancy rates and a high proportion of patients who cannot pay the full costs of their care. A lack of incentives and models for developing appropriate networks of care may result in an increasingly fragmented health service delivery system.

Rural areas are finding it increasingly difficult to recruit and retain the variety of qualified health personnel they need. In some isolated and "unattractive" areas, an absolute lack of providers may become a chronic situation. The number of areas designated by the Federal Government as primary care Health Manpower Shortage Areas (HMSAs) has not changed significantly since 1979. *And in 1988, 111 counties in the United States, with a total population of 325,100, had no physicians at all (31).* Half a million rural residents live in counties with no physician trained to provide obstetric care; 49 million live in counties with no psychiatrist. States overwhelmingly rate health personnel shortages as a top problem area and a top focus of State rural health activities (*22*).

*No single strategy is appropriate to all rural areas or all health care providers.* Rural North Dakota is not the same as rural Mississippi. Rural health problems and issues vary dramatically by region, State, and locality. The success of strategies to address these problems will also vary, and some strategies that are vital to a few communities may offer little to others. Furthermore, even in a single State or locality, multiple approaches are more likely than single strategies to obtain results.

The Federal Government cannot fix all rural health problems. It cannot force community consensus, or create new structures directly adapted to local needs, or overcome all State-level barriers to change. But it can create an environment that facilitates these activities, it can furnish the information States and communities need to know before undertaking them, and it can be the catalyst for great improvements in the rural health care system.

### *The Federal Role in Rural Health*

The States are heavily dependent on the Federal Government for assistance in maintaining and enhancing rural health care resources; nearly one-half (44 percent) of their resources for rural health activities (e.g., personnel recruitment) come from Federal sources (*22*). Federal health insurance programs such as Medicare are a large additional Federal investment in rural health care.

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[7] This number is calculated from table 2, which includes only MDs. The number would be even greater if doctors of osteopathy were included.

The bulk of the Federal role in rural health is carried out through four different types of programs.[8] First are health care financing programs—most notably, Medicare and Medicaid—which pay directly for health care services. Both programs differentiate in a number of ways between rural and urban providers and payment to those providers. Both programs also include special exemptions to general payment rules for certain rural facilities and services (e.g., ohysician services provided in certain HMSAs).

Second is the health block grant, under which the Federal Government allocates funds to States to spend on any of a variety of programs in a general topic area. Three major block grants influence rural health services: the Maternal and Child Health block grant; the Preventive Health and Health Services block grant; and the Alcohol, Drug Abuse, and Mental Health block grant.

Third are Federal programs for which enhancing rural health resources is an explicit goal. Box A presents some major programs in this category.

A fourth critical Federal activity is that of coordinating, undertaking, and funding research on rural health topics. Major Federal agencies involved in this activity are the Office of Rural Health Policy (ORHP) and the Agency for Health Care Policy and Research.

A major challenge in designing Federal rural health policies is to identify those areas where residents' access to basic health care is sufficiently endangered to justify special protective measures. Endangered areas—those with chronic shortages of health personnel, for example—require special attention and ongoing subsidies of providers in order to ensure a basic level of adequate health care to area residents. Although the present HMSA and Medically Underserved Area (MUA) designations have shortcomings, *the basic concept of designating areas of personnel shortage and areas of poor health is sound. Extending this concept to encompass rural hospitals and other facilities would enable more appropriate targeting of Federal health funds to needy rural areas.*

### *Box A—Federal Programs To Enhance Rural Health Resources*

Federal rural health resource programs include:

- *the National Health Service Corps*, which (in addition to having some commissioned members) provides placement services, scholarships, and educational loan repayment for physicians and certain other health professionals willing to serve in certain designated HMSAs;
- *programs that provide grants to schools educating and training primary care providers* (e.g., family practitioners, physician assistants, and nurses);
- *the Federal Area Health Education Centers program*, which links medical centers with rural practice sites to provide educational services and rural clinical experiences to students, faculty, and practitioners in a variety of health professions;
- *the Community and Migrant Health Centers grant programs*, which are the Federal Government's most prominent activities to promote primary health care facilities in rural areas;
- *Primary Care Cooperative Agreements*, through which the Federal Government assists States that are assessing needs for primary health care and developing plans and information to address those needs; and
- *the Rural Health Care Transition Grant program*, established in 1988, which provides grants to small rural hospitals for strategic planning and service enhancement.

Many rural areas are prospering and have sufficient health resources, although these resources may not always be available or provided in an efficient manner. Others have temporary health care problems, and in still other areas health providers face financial crises because they are losing their most lucrative patients to urban hospitals and physicians. *In rural areas without critical and chronic problems of endangered access, Federal policies are more appropriately oriented towards measures to enhance the capabilities of providers, encourage their adaptation to changes in the health care environment, and ensure consistent and fair payment policies.* Appropriate measures may include technical assistance, occasional and temporary financial

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[8] Some other Federal programs also may play a significant role in promoting the health of rural residents (e.g., the Women, Infants, and Children food distribution program of the Department of Agriculture), but those programs are not detailed here.

*Photo credit: Gail Mooney*

Eight-bed Comfrey Hospital, Minnesota's smallest hospital, includes an operating room, outpatient clinic, and 24-hour emergency room.

assistance, targeted financial incentives, and indirect supports.

A secondary problem for Federal rural health policies has been how to identify areas that require special protection, while accommodating the tremendous diversity in rural health issues and problems in different areas of the country. *Effective targeting of Federal resources to rural areas requires the involvement of the States.* State involvement includes not only enlisting the assistance of State and local agencies in identifying critical areas but enabling States and localities to adopt and adapt programs tailored to their own needs. Nearly one-half of States—21 of 44 States responding to an OTA survey—already rely on their own designation criteria instead of (or in addition to) Federal criteria for identifying underserved areas.

The enormous diversity across States in rural health problems suggests that it is also appropriate to maintain a strong State role in designing and implementing solutions. But State capabilities to carry out this role successfully vary considerably. Federal coordination, technical assistance, and information are crucial to States and communities trying to address their rural health needs.

## RURAL HEALTH SERVICES: ISSUES AND OPTIONS

### *Issues*

The 1980s brought major changes to the Nation's rural community hospitals, as medical practices, technologies, and payment systems all acted to replace inpatient procedures with outpatient care and as remaining inpatient care became increasingly sophisticated. Both rural and urban hospitals witnessed substantial declines in inpatient utilization (table 1). Changes in rural hospitals, however, were especially dramatic. Rural hospital occupancy rates[9] in 1988 were only 56 percent, compared with over 68 percent for urban community hospitals (*2*). With lower inpatient admissions, rural hospitals have become more dependent on outpatient and long-term care revenue. By 1987, nearly one-half (46 percent) of rural hospital surgery was performed on outpatients. One-fourth of rural hospitals have long-term care units, and in these hospitals long-term care beds make up nearly one-half of the total beds (*20*).

These major declines in inpatient utilization, compounded by increasing amounts of uncompensated care, have undermined the financial health of many rural hospitals. From 1984 to 1987, the amount of uncompensated care delivered by rural

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[9] These occupancy rates are based on total hospital beds, including long-term care beds.

**Table 1—Characteristics of Metropolitan and Nonmetropolitan Community Hospitals, 1984-88**

| Characteristic | Year |  |  |  |  | Percent change 1984-88[a] |
|---|---|---|---|---|---|---|
|  | 1984 | 1985 | 1986 | 1987 | 1988 |  |
| Number of hospitals |  |  |  |  |  |  |
| Metro | 3,063 | 3,058 | 3,040 | 3,012 | 2,984 | -2.6% |
| Nonmetro | 2,686 | 2,674 | 2,638 | 2,580 | 2,548 | -5.5 |
| Average number of beds/hospital |  |  |  |  |  |  |
| Metro | 256 | 252 | 248 | 246 | 246 | -3.9 |
| Nonmetro | 86 | 86 | 85 | 83 | 83 | -3.5 |
| Total number of beds |  |  |  |  |  |  |
| Metro | 784,311 | 771,807 | 756,033 | 741,381 | 734,073 | -6.4 |
| Nonmetro | 232,740 | 229,871 | 223,422 | 216,021 | 212,224 | -8.8 |
| Total admissions (millions) |  |  |  |  |  |  |
| Metro | 27.7 | 26.6 | 26.0 | 25.8 | 25.6 | -7.7 |
| Nonmetro | 7.5 | 6.8 | 6.4 | 6.0 | 5.9 | -21.0 |
| Occupancy rate (percent) |  |  |  |  |  |  |
| Metro | 71.5 | 67.5 | 67.0 | 67.7 | 68.4 | -4.3 |
| Nonmetro | 60.7 | 56.8 | 55.1 | 55.3 | 55.7 | -8.2 |
| Average length of hospital stay (days) |  |  |  |  |  |  |
| Metro | 7.4 | 7.1 | 7.1 | 7.2 | 7.2 | -2.7 |
| Nonmetro | 6.9 | 6.8 | 7.1 | 7.3 | 7.4 | 7.2 |
| Total number of inpatient days (millions) |  |  |  |  |  |  |
| Metro | 205.0 | 189.9 | 184.5 | 183.3 | 183.6 | -10.4 |
| Nonmetro | 51.7 | 46.7 | 44.0 | 43.8 | 43.3 | -16.1 |
| Total outpatient visits (millions) |  |  |  |  |  |  |
| Metro | 173.1 | 178.9 | 188.0 | 198.5 | 217.3 | 25.5 |
| Nonmetro | 38.8 | 38.6 | 42.9 | 47.0 | 51.8 | 33.5 |
| Total emergency visits (millions) |  |  |  |  |  |  |
| Metro | 57.2 | 58.4 | 59.9 | 61.2 | 63.6 | 10.9 |
| Nonmetro | 15.7 | 16.1 | 16.7 | 17.1 | 17.7 | 12.8 |
| Outpatient surgeries as a proportion of total surgeries |  |  |  |  |  |  |
| Metro | 28.1 | 34.5 | 39.8 | 43.4 | 46.2 | 64.4 |
| Nonmetro | 26.3 | 34.7 | 42.1 | 45.8% | 48.8 | 85.3 |

[a] Numbers in this table do not correspond exactly to the percentage change in every case due to rounding of some table entries. See tables in ch. 3 for more detailed data.

SOURCE: American Hospital Association, Hospital Statistics (Chicago, IL: 1985-89 eds.).

hospitals increased by over 26 percent, to an average of more than $500,000 per hospital by 1987 (*7*). Nonpatient sources of revenues—in many cases, tax subsidies—have become increasingly important to hospitals' financial viability. By 1987, nearly all rural hospitals had higher costs than patient care revenues; the smallest hospitals had costs higher than revenues from all sources (*20*).

Nearly three-fourths of rural hospitals have fewer than 100 beds (figure 3). *These small hospitals are in particular difficulty; they have the fewest admissions, the lowest occupancy, and the highest expenses per inpatient day of all rural hospitals (20).*

Despite these trends, rural areas in general are still well-supplied with hospitals. In 1986, the ratio of community hospital beds to population was about the same in rural as in urban areas; in 14 States, bed-to-population ratios were higher in rural areas (*13*). Most rural hospitals are within a reasonable distance of another hospital (over 80 percent are within 30 miles), but extreme regional differences exist; for example, hospitals are much farther apart

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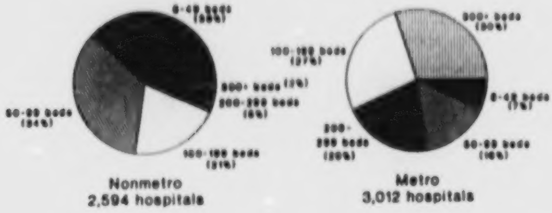
**Figure 3—Distribution of Community Hospitals[a] in Metropolitan and Nonmetropolitan Areas, 1987**



[a]OTA's definition of community hospital differs slightly from the definition used by the American Hospital Association (see app. D for explanation of differences.)

SOURCE: Office of Technology Assessment, 1990. Data from the American Hospital Association's 1987 Annual Survey of Hospitals.

in the less densely populated West (*16*).[10] Although the mid-1980s witnessed a 5.5 percent decline in the number of rural hospitals (table 1), most hospitals that have closed in recent years have been small facilities with low occupancy rates (*35,36*). Most communities in which hospitals closed appear to continue to have reasonable access to emergency and acute care.

In fact, *one of the greatest problems rural hospitals face is the outmigration of rural residents to urban areas for care.* Studies suggest that rural residents (especially young and affluent residents) have been increasingly seeking care outside their own communities, either to obtain specialized care not available locally or to obtain alternatives to locally available services (*4,6,7,17*).

Problems faced by publicly funded facilities that provide primary care services are somewhat different from those faced by hospitals. From 1984 to 1988 the number of rural C/MHC service sites remained relatively constant, but patient visits to rural C/MHCs rose nearly 19 percent during this period (*30*). Most of the increase in utilization appears to be by rural residents unable to pay the full costs of their care. *By 1987, nearly one-half of all rural C/MHC users received discounted care.* Moreover, Medicaid-reimbursed visits constitute an increasing proportion of revenues, while the proportion of revenues from private pay patients has decreased (*30*). Consequently, C/MHCs remain heavily dependent on Federal grant funds, which make up nearly one-half of total revenues.

Despite their heavy Federal dependence, rural C/MHCs receive 15 percent less Federal funding per patient served than do their urban counterparts (*9*). Factors such as differences in the complexity of care patients require may explain some of the difference in funding but have not been studied in detail.

Rural health care facilities have a number of options in adjusting to recent changes in the health care and fiscal environment, ranging from short-term options such as staff consolidation and reduction to longer term strategies such as diversification and participation in multifacility alliances. But many rural facilities have not successfully applied these strategies.

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[10] Eleven percent of rural hospitals are located in "frontier" counties (*20*).

Photo credit: Tim Henderson

Great distances in areas of sparse population can limit the availability of even the most basic local rural health services.

One major barrier to the successful implementation of strategies is simple lack of community and provider will, particularly in cases where groups have differing views on appropriate actions. But even when providers have a firm direction and committment, they can be stymied by a lack of information on the success of alternative possible strategies, and the lack of community and provider technical expertise and financial resources to undertake strategic planning and other important steps. Other especially important structural barriers can include:

- *standards and requirements for Rural Health Clinics (RHCs) and C/MHCs*, including delays in the RHC certification process and C/MHC efficiency standards that may be difficult for small or isolated C/MHCs to meet;
- *regulations to prevent fraud and abuse* that may inhibit hospitals from engaging in some actions that would encourage physicians to practice in a rural area;
- *State licensure restrictions* that prevent hospitals from reducing the scope of services (e.g., converting to a facility that offers only emergency, subacute, and primary care); and
- *restrictions on public hospital activities* that prevent the 42 percent of rural hospitals that are publicly owned from providing services not expressly or implicitly permitted by their enabling statutes.

Federal intervention will have limited effect on some of these barriers. But the Federal Government can avoid policies that send contradictory messages to rural providers. For example, it may be appropriate for many rural hospitals with low occupancy rates to reorient their services to place more emphasis on outpatient care. Any changes in Federal payment policies for ambulatory surgical services that assumed an unrealistically low cost of providing such services, however, might dissuade these hospitals from making appropriate changes. Unintentional disincentives could be minimized by performing a detailed analysis of the impact of any proposed new payment system on rural providers before adopting such a system.

In addition to evaluating potential new health policies for their impact on rural facilities, the Federal Government could take a number of specific steps to identify and protect essential rural health services, and to enhance the abilities of all rural providers to respond appropriately to changes in the health care and economic environment. Options for undertaking these steps are presented below.

### *Options for Congressional Action*

#### Identifying and Supporting Essential Rural Health Facilities

In some rural areas, particularly those with high poverty or very low population density, a single facility may be the only provider of some of the community's vital services. At a minimum, these vital services include basic emergency, primary, acute, and long-term care.

At present there are several programs aimed at identifying (and supporting) facilities providing one or more of these services, specifically the C/MHC grant programs and Medicare's payment exceptions for designated RHCs, Sole Community Hospitals (SCHs), Essential Access Community Hospitals, and Rural Primary Care Hospitals. The assumption of each of these programs is that Federal subsidies or special exceptions to payment rules will enable services to be provided to populations whose health care access might otherwise be severely impaired. Existing programs, however—most notably the SCH program—imperfectly identify these facilities. Furthermore, each program has its own unique criteria that may not be relevant to other applications. One potential direction for Federal policy is to undertake a more concerted effort to identify (option

1) and protect (suboptions 1A-1C) a broad range of essential facilities.

**Option 1: Develop criteria to identify health facilities that provide essential emergency, primary, acute, and long-term care in specified rural areas, and develop programs to provide support for these facilities.**

The Department of Health and Human Services (DHHS) could be directed, with assistance from the States, to make a comprehensive effort to develop criteria that could be used to designate essential facilities and services, which would then be eligible for a variety of Federal and State protections. Criteria could distinguish among facilities for which no reasonable alternatives exist, facilities for which alternatives exist but are more distant or otherwise less accessible, and all other facilities. Programs using the facility designations thus might be applied to either the most narrowly or the more broadly defined group of "essential" facilities.

Designation criteria for essential facilities might include:

- distance/time to nearest comparable and nearest higher level service or facility, considering geographical and transportation limitations;
- level of medical underservice and indigence of the area population;
- institution's area market share and measures of community acceptance (e.g., utilization patterns);
- evidence of plans or actions by the facility to serve critical unmet needs of the local community; and
- other relevant factors (e.g., number of Medicare beneficiaries served).

. From the State perspective, Federal criteria often seem inflexible and not adaptable to relevant local conditions. *To minimize this problem, the development of designation criteria should include the input and active involvement of State governments.* State flexibility would be further enhanced by the establishment of:

- *minimum criteria* to aid the Federal Government in basic and fair allocation of funds among States; and
- *less restrictive criteria* to enable States to use and modify the designations for their own purposes, and to enable more flexibility in the application of Federal programs to variously identified facilities.

Some of the difficulties of applying detailed criteria from the perspective of the Federal Government could be avoided by requiring States to actually apply the criteria and make the designations (see option 2). The Federal role could be restricted to technical support and assistance, reviewing and approving designations and affirming that the designated facilities were eligible for relevant Federal programs. Facilities, once designated, could also be periodically "recertified" in order to remove those facilities no longer meeting the criteria.

*Option 1A: Provide direct grants and subsidies to eligible facilities.*

These could include:

- *Time-limited subsidies* to maintain operations, and to plan and implement strategies to change the scope or delivery of services (e.g., 1- to 3-year grants through an expanded Rural Health Care Transition Grant Program).
- *Continued grant support and/or special alterations in public sources of reimbursement* to maintain and enhance operations for facilities deemed unable to achieve self-sufficiency due to isolation or high levels of unreimbursed care. For example, designated hospitals could continue to receive reimbursement exceptions under the Medicare program. Alternatively, the SCH exception could be phased out altogether, and general subsidy grants analogous to those provided to C/MHCs could be made available to all eligible hospitals, separating the subsidies from the Medicare program.

*Option 1B: Require the Farmers Home Administration (FmHA), the Department of Housing and Urban Development (HUD), and other Federal agencies to give special attention to the needs of essential rural health facilities when making available loans to institutions for capital improvement.*

Many essential rural hospitals and clinics may lack adequate access to capital for diversifying services and converting facilities to other functions. Many of these providers' basic facilities and equipment also may need upgrading to maintain quality of care and conform to Federal and State regulations. Increased availability of capital through FmHA direct and guaranteed loans and HUD loan guarantee programs could help to ensure the financial stability and presence of these facilities.

*Option 1C: Protect essential facilities from Federal fraud and abuse regulations that inhibit their ability to recruit and retain physicians or to be acquired by physicians.*

Close organizational association with physicians may be the only financially feasible strategy for long-term survival for some rural facilities, and for essential facilities the benefits of financial stability may sometimes outweigh the dangers of potential conflicts of interest. A specified "safe harbor" from fraud and abuse regulations, or a legislative exemption to these laws, could provide for the arrangements these facilities might make to ensure the availability of a local physician (e.g., free onsite office space). In addition, specified "safe harbor" practices could encompass the purchase of small, failing hospitals by local physicians wishing to ensure the availability of this resource. Whole or partial physician ownership of health care facilities may be an especially attractive option in the case of small "alternative licensure" facilities that provide mostly primary, emergency, and subacute care.

To guard against abuse of this exemption, restrictions could specify that incentives be independent of the number of patients the physician refers to the facility, or that a facility wishing to acquire a physician practice could not exclude other local physicians from its staff. Also, facilities could be precluded from listing recruitment and retention costs on their Medicare cost reports.

**Option 2: Provide assistance to States to help them identify essential facilities, remove regulatory barriers applying to these facilities, and offer State-based financial support to a more flexible set of designated facilities.**

*Option 2A: Provide time-limited (1- to 3-year) grants for the development of State-designated offices of rural health to enable States to better support rural health efforts.*

The Federal ORHP is an important part of the Federal effort to assess rural health program needs and respond to information needs. Organizations that can carry out equivalent duties at the State level are likewise important. As of February 1990, 19 States had instituted (and 5 more had plans for) State-designated offices of rural health (*14,22*). (Locations of existing offices were almost evenly divided between State agencies and nonprofit organizations.) Thirty-four States reported the existence of legislative or executive task forces or committees to address State rural health issues (*22*). Thirteen States, however, have neither an office of rural health nor a State rural health task force.

*Option 2B: Provide time-limited or ongoing grants to States to help them undertake specific activities relating to essential and other rural health facilities.*

Such grants could enable States to:

- identify and designate essential facilities and services;
- monitor the financial condition of essential facilities and services, protect against undesirable closure, and examine the comparability and acceptability of the nearest health care facilities;
- provide technical assistance to enhance leadership and management skills, support strategic planning, encourage reconfiguration of services and cooperative affiliations with other institutions, and recruit critical staff;
- help subsidize existing statewide capital financing sources and/or uncompensated care pools, making them more accessible to essential facilities;
- encourage special local tax initiatives and the creation of health service districts, where appropriate, to maintain and expand services;
- study the impact of Federal and State regulations on essential facilities, disseminate information clarifying State and Federal regulatory requirements, and develop model State legislative and regulatory language; and
- identify areas without access even to essential primary and other care facilities, and provide funds to establish new facilities in these areas.

### Encouraging Comprehensive and Coordinated Rural Health Care

Rural patients and providers are often both physically and professionally isolated. As a result they may be unable to obtain consultation and information and unaware of appropriate alternative sources of care. They may receive little feedback and few resources from regional providers.

**Option 3: Award small Federal grants to projects whose goal is the development of model rural health care networks.**

Short-term demonstration and development grants could be awarded by DHHS to States or nonprofit organizations to:

- identify special basic care need areas in geographically remote and persistent poverty communities, identify minimum service needs, and create and evaluate the effectiveness of service networks in those areas;
- identify regional needs and service resources for comprehensive and integrated care in regions *not* designated as special basic care need areas, and create and demonstrate integrated care networks in those regions; and
- develop regional referral networks for specific services and population groups needing particular attention, using (and expanding) the perinatal network model.

Some aspects of this option are already in place; for example, under Primary Care Cooperative Agreements, States can receive funds to help identify needs in underserved areas. Private organizations, however, cannot receive funds directly at present for this purpose.

As an alternative to a new funding program, the Rural Health Care Transition Grant program could be expanded. A proportion of these grant funds could be directed specifically to funding for consortia of hospitals and other providers wishing to develop model arrangements for transferring and referring patients, and for enhancing local care through periodic specialty clinics and continuing education seminars.

### Longer Term Assessment of the Future of the Rural Health Care Delivery System

Innovative responses to existing barriers to change include measures to modify State hospital licensure laws to permit the operation of facilities that provide less than full-service hospital care. Two examples are Montana's Medical Assistance Facilities and California's proposal for basic facilities whose license category would depend on the extent of services they offer. The Federal Government has taken similar steps with the enactment of the Omnibus Reconciliation Act of 1989 (Public Law 101-239), which permits Medicare payment to small rural facilities that are designated Rural Primary Care Hospitals (RPCHs) in a limited number of States. But the RPCH is not necessarily the only or the best model for all rural areas, and the ability of other facility models to be eligible for Medicare and Medicaid payment remains highly uncertain.

*The need for such "alternative licensure" facilities, the variety of proposals, and the potential importance of these facilities to the rural health care system warrant a comprehensive and ongoing analysis to ease their incorporation into the system.* Adapting the system to accommodate these facilities introduces a myriad of questions: how to pay for the services they provide, how to integrate them into a comprehensive and coordinated system of care, and how to ensure that they continue to provide services vital to their communities. Answering these questions requires the input and coordination of information from a variety of Federal and State agencies.

The recently established ORHP and the National Advisory Committee on Rural Health were created, in part, to address such issues. At present, ORHP has a very small staff and a wide range of responsibility; the Advisory Committee considers a similarly broad range of issues and meets only four times each year. These limitations at present prevent an immediate, intense examination of the structure of the rural health care system.

**Option 4: Establish a short-term (18-24 month) advisory task force whose purpose is to examine the future of rural health delivery systems and to provide guidance on the implementation of new service delivery structures.**

Ideally, the task force, comprising both public- and private-sector experts in rural health and health care financing, would meet frequently and would advise DHHS and Congress. It could be coordinated with the current Advisory Committee—for example, by having representatives from the Advisory Committee serve as part of the short-term task force. The task force could be staffed by an augmented ORHP to eliminate duplication of effort.

The immediate objectives of the task force could include:

1. assisting DHHS in the development of criteria for identifying essential facilities (see option 1);
2. developing guidelines under which projects may demonstrate the feasibility of alternative facility and service delivery models and (if necessary) obtain waivers from Medicare and Medicaid certification requirements;

3. expanding and coordinating discussion on potential methods of payment to these facilities (e.g., prospective payment groups, integrated payment for physician and hospital services); and
4. providing directions for research and demonstration efforts supporting the development of model service delivery networks in rural areas (see option 6).

To ensure that the recommendations of the task force could be implemented, DHHS would need to maintain or develop complementary expertise. For example, DHHS staff might need to be able to:

- compile, analyze, and make available information on existing efforts to develop model service structures and networks;
- help States and local communities to identify regional needs and determine standards for acceptable access to comprehensive services; and
- participate in the development of both new projects to demonstrate innovative service and facility categories in rural areas (e.g., subacute care facilities) and networks involving such providers.

### Addressing Information Needs

**Option 5: Expand basic research on access to health care in rural areas.**

Specific topics that DHHS could be encouraged or mandated to study include:

- Nationwide migration patterns of rural residents for health services outside their local communities, why they occur, and their impact on the economic viability of local health services (particularly obstetrics services).
- How travel distances and transportation limitations affect access to hospital care in rural areas.
- The costs to rural hospitals, under different conditions, of restructuring their organization and services in various ways (e.g., capital, operating, and regulatory costs of downsizing hospitals to alternative delivery models).
- The availability, accessibility, and general operating characteristics of rural C/MHCs, particularly those in persistent poverty and frontier regions; special problems these centers face; whether these centers are able to provide a sufficient scope of care, particularly obstetrics care; and how critical they are as a source of primary care.

**Option 6: Expand funding to the Office of Rural Health Policy to administer an extended clearinghouse of information on innovations and successes in rural health delivery.**

Many States and communities would like to investigate and implement improved forms of health service delivery but do not have, and are unable to purchase, the necessary knowledge and expertise. The Federal Government has a unique capability to act as a central point for information collection and dissemination. In addition, the Federal Government has an interest in providing assistance relating to State and local implementation of current programs in order to enhance the effective use of Federal funds.

ORHP's current efforts to develop an information clearinghouse could receive supplemental support to:

- contract researchers to develop extensive case studies of various rural service delivery innovations;
- work closely with private groups funding innovative rural health delivery demonstration projects to document and disseminate information on project activities and findings; and
- routinely analyze information collected on innovative strategies, identify those that appear to have the broadest benefit and transferability, and identify factors that will affect their applications in other areas.

## RURAL HEALTH PERSONNEL: ISSUES AND OPTIONS

### *Issues*

### Availability of Personnel[11]

***Physicians***—Physicians have historically been the cornerstone of the health care system, and physician supply has been increasing for many years in both rural and urban areas (table 2) (*33*). Despite the overall increase, however, rural areas have fewer than one-half as many physicians providing patient care as urban areas (91 *v.* 216 per 100,000 residents in 1985) (table 2) (*33*). In the least populated

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[11] This report did not examine the availability of chiropractors or podiatrists.

**Table 2—Physician-to-Population Ratios (MDs only) by County Type and Population, 1979 and 1988[a]**

| | 1979 | 1988 | Percent change, 1979-88 |
|---|---|---|---|
| **Total MDs per 100,000 residents[b]** | | | |
| Metro | 219.3 | 262.6 | 19.7 |
| Nonmetro | 87.2 | 108.5 | 24.4 |
| 50,000 and over | 116.3 | 146.7 | 26.1 |
| 25,000-49,999 | 86.8 | 106.2 | 22.4 |
| 10,000-24,999 | 62.0 | 74.7 | 20.5 |
| 0-9,999 | 48.6 | 58.2 | 19.6 |
| U.S. total | 188.4 | 227.7 | 20.9 |
| **Patient care MDs per 100,000 residents[b]** | | | |
| Metro | 174.3 | 215.6 | 23.7 |
| Nonmetro | 73.3 | 90.5 | 23.5 |
| 50,000 and over | 97.5 | 122.2 | 25.3 |
| 25,000-49,999 | 73.3 | 89.9 | 22.6 |
| 10,000-24,999 | 52.0 | 61.3 | 17.9 |
| 0-9,999 | 40.5 | 47.5 | 17.4 |
| U.S. total | 150.7 | 187.2 | 24.3 |

[a] MD data for 1988 are as of Jan. 1. Prior to 1988, data are as of Dec. 31.

[b] 1987 population estimates were used to calculate 1988 MD ratios. Prior to 1988, population estimates used were for the same year as MD data.

SOURCE: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Data Analysis and Management, Rockville, MD, unpublished data from the Area Resource File system provided to OTA in 1989 and 1990.

counties (those with fewer than 10,000 residents), there are only 48 physicians for every 100,000 people—about one physician for every 2,000 residents. Over 100 U.S. counties have no practicing physicians at all (*31*).

The availability of primary care physicians in rural areas is of particular concern. Primary care physicians make up well over one-half of all physicians who provide patient care in rural areas (table 3), but these areas are increasingly competing with urban practices (such as those associated with health maintenance organizations) for primary care physicians. Osteopathic physicians (DOs), who constitute about 9 percent of the total U.S. physician population, make up a large proportion of rural primary care physicians. In small rural counties in some States, as many as three-fourths of the physicians are DOs (*12*).

**Table 3—Availability of Primary Care Physicians by County Type and Population, 1988[a]**

| | Primary care physicians[b] | |
|---|---|---|
| | Number per 100,000 residents | Proportion of all active physicians[c] |
| Metro | 86.8 | 38% |
| Nonmetro | 55.3 | 57 |
| 50,000 and over | 61.8 | 48 |
| 25,000 to 49,999 | 56.1 | 58 |
| 10,000 to 24,999 | 48.5 | 71 |
| 5,000 to 9,999 | 45.9 | 81 |
| 2,500 to 4,999 | 43.4 | 82 |
| Fewer than 2,500 | 25.6 | 78 |
| U.S. total | 79.7 | 40 |

[a] Includes Jan. 1, 1988 MD data and 1987 DO data.

[b] Primary care physicians include professionally active MDs in general/family practice, internal medicine, pediatrics, and obstetrics/gynecology; and all doctors of osteopathy in patient care.

[c] Professionally active physicians include physicians in research, administration, and teaching, and physicians in Federal service.

SOURCE: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Data Analysis and Management, Rockville, MD, unpublished data from the Area Resource File System provided to OTA in 1989 and 1990.

*Midlevel Practitioners*—Nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) have become important medical care providers in rural areas and are the only licensed providers of primary health care in some areas with no physicians. Their small numbers are increasing, although there appears to be a very gradual trend toward specialization and urban practice even for these practitioners. The distribution of midlevel practitioners varies enormously by State; these professionals are most likely to be found in States with midlevel practitioner schools and in States that permit more independent practice.

Certified registered nurse anesthetists (CRNAs) are another midlevel profession that is especially important to small rural hospitals that wish to provide basic surgical services but cannot support or attract physician anesthetists. The national supply of CRNAs, however, appears to be in decline.

***Nurses***—Rural hospitals have markedly fewer registered nurses (RNs) and lower ratios of RNs to licenced practical/vocational nurses than do their urban counterparts (*32*). The proportion of RNs who work in rural areas has decreased in recent years, and rural areas will probably continue to be at a disadvantage when competing for the shrinking national supply of nurses.[12] On average, nurses in smaller rural counties are considerably older than other nurses and are less likely to have baccalaureate nursing degrees, making upgrading to midlevel degrees (e.g., NP) more difficult.

***Dentists***—As with physicians, the number of dentists and the proportion of dentists entering specialty practice have increased considerably over the past two decades. However, rural areas have considerably fewer dentists per capita than urban areas, and projected future shortages of dentists are likely to worsen the situation (*33,34*). Despite the large number of dentists in general at the present time, there remains a small but constant demand for dentists in areas with chronic or occasional difficulty recruiting these practitioners.

***Pharmacists***—There has been no national census of pharmacists since the 1970s, and the number of pharmacists practicing in rural areas is unknown. The national supply of pharmacists is projected to increase (*33*). A handful of State studies suggest that urban/rural differences in distribution are less severe for pharmacists than for many other health professionals, but little is known about the existence of local areas of shortage.

***Optometrists***—Optometrists may be important providers of vision care in rural areas without ophthalmologists. One-third of all optometrists (and one-fifth of ophthalmologists) were practicing in communities of 25,000 or fewer residents in 1983 (*3*). As with pharmacists, the national supply of optometrists is increasing (*33*), although some local shortages may exist.

***Allied Health Professionals***—The allied health professions include a wide variety of laboratory personnel, therapists, technologists, emergency personnel, dental hygienists, and other professionals. A study by the Institute of Medicine, which examined 10 different allied health professions, predicted serious impending shortages in the national supply of physical and occupational therapists, radiologic technologists, and medical records specialists (*10*). The available anecdotal evidence and small-area studies suggest that some rural facilities are already suffering critical shortages of physical and occupational therapists and some radiologic and laboratory personnel.

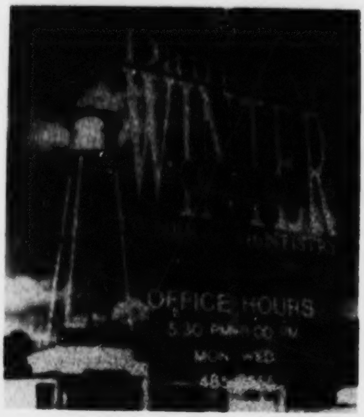

Photo credit: Peter Beeson

Some rural communities have limited access to basic dental services.

### Barriers to Rural Practice

Barriers to the availability and willingness of health professionals to locate in rural areas intervene at two levels. First, because rural areas often have populations too sparse or dispersed to support many subspecialty physicians, *an inadequate supply of primary care physicians and midlevel practitioners is a barrier to the availability of health care services in rural areas even if there is an oversupply of physicians overall*. Although the supply of physicians has grown dramatically in the past two decades, most of the increase has been among nonprimary care specialists. The backbone of the rural health care system, however, is primary care physicians—those who can provide a wide array of basic health services to small communities that

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[12] Nursing school enrollment actually increased slightly in academic year 1987-88, but long-term projections are still pessimistic.

*Photo credit: Peter Beeson*

Satellite clinics that are staffed part-time can be a vital source of primary care services in many rural communities.

cannot support a full complement of specialists. Recent Federal policies have addressed this barrier by redesigning Medicare payment to enhance payment for many primary care services. Further Federal options discussed below include supporting primary care physician and midlevel education directly or through changes in Medicare reimbursement for direct medical education.

Second, within a given group of professionals (e.g., primary care physicians), *personal concerns, perceived lower financial rewards, professional isolation, and lack of preparation for rural practice prevent many practitioners from locating and staying in rural areas.* Strategies to address these barriers and concerns through rural-oriented training programs and direct financial incentives for rural practice have had some success in the past. Federal measures to address disincentives to rural practice have been in place for two decades, but during the 1980s their funding declined. Options for reinstating Federal interventions include targeting funding to rural-oriented health professions programs and offering direct incentives to health professionals through scholarships, educational loan repayment, and special payment or practice provisions that apply to health professionals in underserved rural areas. The Federal Government could also choose to enhance other resources available to rural practitioners (e.g., technical assistance, continuing education, long-distance consultation resources). *Combinations of strategies, rather than any single strategy, are likely to be the most effective in improving the availability of health professionals in rural areas.*

## *Options for Congressional Action*

### Influencing the Supply of Primary Care Physicians

**Option 8: Reorient or augment existing Federal funding for graduate medical education to direct resources to primary care specialties (family practice, general internal medicine, general pediatrics, and obstetrics/gynecology).**

*Option 8A: Expand Federal grant funding for primary care undergraduate and graduate medical education.*

The Federal Government provides grants to family practice, general internal medicine, and general pediatric residency programs, but these grants declined substantially between 1980 and 1988. Grants for the development, improvement, and maintenance of undergraduate departments of family medicine have also decreased in recent years. Targeted funding for primary care education is one strategy for overcoming some of the disincentives for specialty training in primary care.

*Option 8B: Weight Medicare reimbursement for direct medical education costs to give preference to primary care specialties.*

Medicare reimbursement to hospitals for direct graduate medical education expenses does not distinguish among specialties. By altering the payment formula to give greater weight, and thus provide greater resources, to specified primary care specialties, it may be possible to alter the mix of physician specialists without further increasing the total number of physicians. A difficulty in implementing this option would be that of developing an adequate rationale for the specific weights to be assigned to each specialty. An advantage, compared with option 8A, is that it could be adopted without increasing overall levels of funding.

### Enhancing Training and Preparation of Rural Health Personnel

**Option 9: Within Federal grant programs for primary care medical education, target funding to rural-oriented programs.**

*Option 9A: Target a fixed percentage of grant funds for graduate medical education specifically to programs that emphasize preparation for practice in rural and underserved areas.*

To be eligible for grants, programs could be required to encourage rural/underserved practice by incorporating into their curricula activities such as requiring rotations for residents in rural practice settings and providing enhanced training in mental health. Alternatively, eligibility for residency program grants could be made contingent on outcome—e.g., the demonstration that a requisite proportion of graduates were practicing in rural or underserved areas a year after graduation.

*Option 9B: Target a percentage of grant funds for undergraduate medical education specifically to programs that emphasize preparation for primary care practice and for practice in rural and underserved areas.*

Students entering undergraduate medical education with an interest in primary care often switch to subspecialty preferences by graduation. Undergraduate exposure to primary care practice in rural settings has been shown to positively influence the choice for rural primary care practice. Federal grant funds for undergraduate medical education could be targeted to programs providing such opportunities. Funding could also be targeted to schools serving areas of greatest need (e.g., allopathic and osteopathic medical schools in regions of low primary care physician supply), and funded programs could be targets for National Health Service Corps scholarship awards.

**Option 10: Expand funding to training programs for midlevel professionals, giving preference to programs that emphasize preparation for rural practice.**

Midlevel professionals are vital components of the rural health care system, but they are relatively few in number. Furthermore, the rise of HMOs and the expansion of other urban opportunities for midlevel professionals makes it more difficult for rural areas to recruit and retain these providers. Compared with funding for physician education, funding for midlevel training programs and continuing education is very limited. In 1988, only 11 rural-focused NP programs and 1 rural-focused CNM program were funded. Thirty-eight PA training programs are currently supported, many of which are required to develop and use methods designed to encourage graduates to work in health personnel shortage areas.

Current grant programs to health professions schools that train midlevel providers could be expanded and directed towards those programs that incorporate rural-oriented curricula, or that demonstrate success in placing graduates in rural and underserved areas.

**Option 11: Provide grants and traineeships to rural-oriented multiple competency training programs for allied health professionals.**

The availability of trained allied health personnel, and particularly of personnel who can perform more than one function, is becoming increasingly important to the survival of small rural hospitals. The small grant program currently authorized to fund multidisciplinary training programs does not explicitly include cross-training of allied health personnel.

To enhance the effectiveness of a cross-training program, continuation of funding could be contingent on an outcome requirement—e.g., training programs could be required to demonstrate that a substantial proportion of graduates were practicing in rural areas. The availability of traineeships might also enhance the effectiveness of a general program, by providing students from rural and underserved areas the financial incentive and capability to enroll in such a program.

**Option 12: Expand funding for rural Area Health Education Centers, with special emphasis on training and continuing education of nonphysician health professionals.**

The original AHEC concept was to develop multidisciplinary educational experiences. Although AHECs have become increasingly involved in such activities in recent years, most of their resources have been spent on physician education. AHECs are a model for encouraging State and local participation in activities addressing the geographic maldistribution of health professionals. The program is designed to create lasting networks that would eventually be supported entirely through State and local funds. To extend the usefulness of the AHEC model and encourage more comprehensive service delivery systems, future AHEC startup grants could be directed to programs that emphasize the training and continuing education of midlevel providers, mental health providers, and other nonphysician health professionals. AHEC "special initiative" funds could be targeted to existing AHECs for the same purposes. The authority for AHECs could be expanded to enable nursing schools to receive AHEC funds directly.

### Offering Direct Incentives for Rural Practice

**Option 13: Expand the National Health Service Corps (NHSC) by increasing funding for both the State and Federal components of the NHSC Loan Repayment Program and by reinstating a targeted Scholarship Program.**

In 1988, 29 percent of all rural residents were living in federally designated HMSAs (*31*). This number has not changed appreciably during the past 5 years, indicating a need for ensuring the availability of health professionals who have at least a short-term commitment to serving in these areas. Federal investment in the NHSC declined dramatically in the 1980s and is now embodied primarily in Federal- and State-administered loan repayment programs. The Federal Loan Repayment Program was funded at $3.9 million in 1989 and that year recruited 112 professionals, mostly physicians. At present, there are only seven State NHSC Loan Repayment programs.[13]

The Loan Repayment program provides an incentive to recently graduated practitioners that is particularly appropriate for recruiting physicians and dentists, for three reasons. First, it does not require any commitments until the practitioner has finished his or her education, leading to less likelihood of default. Second, recipients are available almost immediately. Third, the level of indebtedness among medical and dental students has increased dramatically in recent years, and the pool of interested applicants to an expanded loan repayment program is likely to be large.

The State and Federal components of the loan repayment program have complementary advantages. The State program efforts are more localized than Federal efforts, and they attract providers who are willing to serve but want the assurance that they can carry out their service obligation within their State of residence. In addition, the program requirement that States match Federal funds encourages greater State participation in health personnel distribution activities.

Maintaining the Federal program would ensure that some obligated providers were available to serve in underserved areas in States without their own loan programs, and it would attract providers interested in new locations.

Available data indicate that the original NHSC Scholarship Program, while expensive, was highly successful at placing providers in shortage areas. A renewed scholarship program would be especially appropriate for midlevel providers. Their relatively low educational costs (compared with those for physicians) lead to correspondingly lower educational indebtedness, making loan repayment a relatively weaker policy tool, while making a scholarship program less expensive for the Federal Government. Scholarships for other health professions students could be targeted to those from low-income, minority, or rural backgrounds. These students are somewhat more likely than others to practice in underserved areas after graduation, and they are less likely to be able to afford the economic burden of a health profession education.

Other measures could also be taken within both the Loan and Scholarship programs to enhance the capabilities of obligated professionals and to increase the likelihood that they would remain after their obligation expires. For example:

- Preference could be given to students who have enrolled in a program with a rural, primary-care-oriented curriculum.
- Participants could be permitted to serve their obligations at a single site regardless of any change in the area's designation status during their period of obligation.
- The NHSC could actively coordinate with other programs (e.g., the AHEC program) to ensure support for scholarship recipients during their education and periods of obligation. Support might include such features as rural preceptorships, practice management training, technical assistance, and continuing education.

A renewed NHSC would be a major investment. If this option were implemented, the program would warrant accompanying oversight (e.g., by the General Accounting Office) in its first years to ensure that funds were appropriately and efficiently administered.

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[13] The seven States are Minnesota, West Virginia, Texas, Florida, North Carolina, South Carolina, and New Mexico.

**Option 14: Encourage or require States to offer bonuses under Medicaid to physicians providing services in designated HMSAs, paralleling the current policy under Medicare.**

This option would extend the benefits of increased access to Medicaid as well as Medicare beneficiaries. It would also increase incentives for physicians less likely to provide services to Medicare beneficiaries (e.g., pediatricians, obstetrician/gynecologists). Medicaid bonuses might be especially appropriate for physicians providing obstetric services in areas with shortages of obstetricians.

**Option 15: Offer tax incentives to health providers in specified rural and underserved areas.**

Direct and time-limited tax incentives for primary care providers (physicians and midlevel professionals) serving underserved populations might overcome perceived or real financial disincentives to locating and practicing in rural areas. Tax incentives could be offered to providers in all rural areas, but this policy could be expensive without improving availability in the areas of greatest need. If these incentives are linked to federally designated shortage or underserved areas, however, their continuation should not be dependent on the continued status of the designation (i.e., if the area is "dedesignated" during the term of the incentive, the incentive should not be removed).

**Option 16: Allow a "grace period" before dedesignating HMSA areas, populations, and facilities.**

For HMSAs with small populations, the addition of a single physician (or the retention of an NHSC physician past his or her period of obligated service) can mean the loss of designated status. The sudden loss of resources dependent on continued designation (e.g., Medicare physician bonus payments, placement of NHSC personnel, and qualification as a Rural Health Clinic under Medicare rules) may produce unintentional negative consequences.

A "grace period" could encourage existing providers to stay while permitting the Federal Government to direct new available personnel to more needy areas. For example, if the addition of a provider in a designated HMSA raises the provider-to-population ratio above the allowable limit and the HMSA is targeted for dedesignation during periodic review, that HMSA could be placed on a provisional list that received close monitoring. HMSAs on the list might receive no new resources but could continue existing resources linked to designation. If at the end of the 2-year period the ratio was still above the allowable limit, that HMSA could be dedesignated. Such a policy could be limited to primary care HMSAs or applied to all types of HMSAs.

**Option 17: Authorize and implement a State rural health personnel grant.**

A drawback to all rural health personnel programs operated from the Federal level is the inability to adapt strategies to local concerns and conditions. A State with a school to train physician assistants, for example, may most effectively address health personnel shortage problems by enhancing this school's curricula and providing scholarships to its students. In another State, absolute health personnel shortages might be less a problem than the provision of specific services, such as obstetrics; such a State might find that paying malpractice premiums for rural obstetrics providers was a more effective strategy than direct recruitment of more physicians to rural areas. A broadly defined grant to States would transfer responsibility to the individual States to decide how they choose to allocate the funds among health professions programs and direct incentive programs to enhance the supply of health professionals in rural areas. Such a grant could either augment existing Federal programs or replace some of them.

Under a rural health personnel grant program, States could be allocated grant funds based on a formula developed by DHHS (e.g., percentage of population that is rural; number of rural residents living in underserved or personnel shortage areas). Within the grant, States could spend funds on any of a list of relevant specified activities such as:

- grants to State health professions schools with rural-oriented curricula;
- Medicaid payment incentives for services provided in underserved areas;
- Medicaid bonus payments for "disproportionate share" providers (those with unusually high caseloads of Medicaid and uninsured patients);
- scholarship and loan programs;
- other recruitment mechanisms (e.g., placement services, State tax incentives);
- purchase of malpractice insurance premiums for rural obstetrics providers (obstetricians,

family practitioners, CNMs, NPs);
- innovative continuing education programs for rural professionals; and
- development of appropriate curricula and establishment of community training programs (e.g., in local hospitals and community colleges) for rural residents interested in one of the allied health professions, and for current allied health personnel wishing to extend their accreditation to more than one area.

The expertise among State governments regarding the administration of rural health programs varies considerably. Some States are capable of designing and administering a detailed array of incentive and grant programs, while others have much more limited capability at present. As a prerequisite to receiving funds under such a grant, States could be required to provide a plan outlining the activities to be funded and indicating that the State has an adequate administrative capability (e.g., an Office of Rural Health or analogous body) to carry out the funding activities. In addition, States could be required to provide the Federal Government with basic information on the programs actually funded over the preceding year as a prerequisite for renewing the grant. This information would not only enable some oversight of expenditures but would provide the basis for the Federal Government to assist in information transfer among States regarding innovative programs.

### Removing Barriers to Midlevel Practice

**Option 18: Require States to reimburse under Medicaid for the services of NPs and PAs in rural areas, as long as these services are permitted by State practice acts.**

Current Federal policy requires States to reimburse under Medicaid for services provided by pediatric and family NPs (Public Law 101-269). It also allows States to exercise the option of reimbursing for other NP and PA services, and nearly one-half of all States now do so to some degree. The Federal policy requiring States to provide Medicaid reimbursement for CNM services provides a precedent for a more general policy. As with CNMs, Federal policy could prevent State Medicaid programs from requiring the direct personal supervision of a physician during the delivery of NP and PA services. Restricting the requirement to rural areas might provide an additional incentive for NPs and PAs to locate in these areas, while a broader policy might encourage their expanded use in urban as well as rural settings.

This option carries weight only where State laws permit midlevel practitioners to operate under offsite supervision. The Federal Government has traditionally not dictated the scope of practice that States permit of their licensed health professionals. (Option 19 addresses a potential Federal role in the reexamination of State licensure restrictions.)

**Option 19. Encourage DHHS to sponsor a conference to discuss models and guidelines for State nurse and medical practice act revision that would enhance the capabilities of midlevel practitioners to provide primary health care in rural and underserved areas.**

Midlevel practitioners can provide a limited number of basic health services in areas not adequately served by physicians. Their ability to do so, however, is legally restricted in many States, particularly for PAs. A conference, sponsored by DHHS, would give representatives from different parts of the government and health care an opportunity to reevaluate the suitability of existing limits to midlevel practice. Participants might include experts from the medical, PA, and advanced nursing professions, representatives from State and Federal agencies, and representatives from other sectors of the health care industry. Guidelines developed by such a panel could help States evaluate and implement appropriate changes to their own regulations.

### Improving the Information Base

**Option 20: Improve monitoring of the Medicare Physician Bonus Payment Program to find out how well it works.**

The Medicare physician bonus program was recently expanded to provide a 10-percent bonus for all physician services in all primary care HMSAs, in order to increase access to services for Medicare beneficiaries. It is not clear whether a 10-percent bonus on Medicare payment is sufficient to attract physicians to areas where they would otherwise not choose to locate, or whether it improves the retention of providers already in these areas. The Medicare caseload varies greatly from physician to physician, and the strength of the bonus incentive probably varies accordingly. To improve DHHS's ability to evaluate the program, carriers could be required to submit to the Health Care Financing Administration data regarding the number of physicians receiving bonus payments and the distribution of services for which bonus payments are made.

**Option 21: Establish a program, through the Bureau of Health Professions, to provide small grants and technical assistance to States and professional associations to establish and implement uniform data collection procedures among the health professions.**

Better data on the supply and distribution of health professionals would improve the Federal Government's ability to monitor trends in the availability of these personnel in rural areas. Most professional associations collect data on the members of their profession, but these efforts are sometimes very limited, and the data are not compatible. States likewise collect data on licensed health professionals, and they may include some professionals not represented in professional association databases. To enhance these efforts with a minimum amount of Federal resources, the Bureau of Health Professions in the Health Resources and Services Administration could establish criteria for uniform data collection. The Bureau could then provide States and associations with technical assistance on survey sample selection methods or on census collection methods, make available startup funds, and offer other appropriate assistance (e.g., for hardware, software, and other resources).

## TWO SPECIFIC SERVICES

### *Issues and Options in Maternal and Infant Care*[14]

Fetal, infant, and maternal mortality are all disproportionately high in rural areas (*27,28*).[15] These indicators of relatively poor rural maternal and infant health persist despite private and government-funded programs that have successfully reduced infant mortality in targeted areas. *Two potential contributors to the relatively poorer health of rural mothers and infants are the limited availability of obstetric providers and access to specialized care for women with difficult pregnancies and deliveries.*

The availability of rural obstetric providers has declined sharply in recent years, and over 500,000 residents of rural counties—many of them in the South—are without any physicians who provide obstetric care. In many rural areas, physicians trained to provide obstetric services are not doing so. Unwillingness is often due to concerns about inadequate sources of backup, consultation, and referral that are shared by rural physicians in all specialties. In addition, however, many physicians are limiting or eliminating their obstetric practices as a direct consequence of the high cost of malpractice insurance and fears of lawsuits. These trends are particularly disturbing in rural areas because alternative sources of obstetric care may be a considerable distance away.

Where there are obstetric providers, they are usually general and family practitioners rather than obstetricians. And although rural hospitals are much more likely than urban hospitals to offer obstetric care, they are much less likely to offer specialized care. Consequently, rural women with complicated or high-risk pregnancies may have to travel considerable distances to receive specialized care. Regionalized perinatal care, successfully promoted in the past by Federal programs, can enhance access to specialty services when obstetric or neonatal emergencies arise, but regionalized systems of care have deteriorated over the past several years.

In some rural areas, women who are able—particularly those with higher incomes and private insurance coverage—are bypassing local facilities to deliver in distant hospitals offering sophisticated services. One result may be to leave local physicians and hospitals with an increasingly higher proportion of patients who cannot pay the full costs of their care. Rural physicians under these circumstances may find it particularly difficult to afford obstetric liability insurance, possibly prompting them to reduce their obstetric practices and further increasing the burden on remaining obstetric providers.

Federal maternal and infant health programs (e.g., Medicaid, the Maternal and Child Health block grant, and C/MHC funds) are especially important in rural areas, where the inability to pay for obstetric services is a serious problem. In 1982, rural deliveries accounted for nearly one-half of all uncompensated deliveries. C/MHCs are particularly important

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[14] See also option 5 and personnel options generally (options 7 through 22).

[15] This finding holds true after adjusting for race and sex. Unadjusted rural infant mortality rates are actually lower than urban rates, because of the greater prevalence of white infants in rural areas.

*Photo credit: Tim Henderson*

Many rural community health centers attract a large cross-section of community residents and may be vital sources of local obstetric care.

sources of prenatal care for many rural women, because they accept all Medicaid patients and provide discounted care for low-income uninsured patients. *But the expense of malpractice insurance has reduced the ability of some federally supported C/MHCs to provide obstetric care (11).* Ensuring survival of essential rural C/MHCs (and their ability to provide obstetric services) is as important to maternal and infant health as ensuring survival of essential rural hospitals.

**Option 22: Extend liability coverage under the Federal Tort Claims Act to C/MHC staff and contract providers engaged in obstetric care.**

The Federal Tort Claims Act currently insures both commissioned officers of the NHSC and NHSC scholarship graduates who work as civilian employees of the Public Health Service. Many C/MHC obstetric providers placed through the NHSC, however, have no federally provided insurance coverage because they are paid through the center. Providing insurance coverage might increase the willingness of obstetric providers to join C/MHC staffs, to remain at these locations, and to continue to provide a full range of obstetric services to C/MHC patients.

**Option 23: Enhance the information base for Federal rural maternal and infant health policy.**

*Option 23A: Investigate in more depth the urban and rural differences in perinatal health status indicators.*

Whether the excess of rural fetal deaths is real or occurs because of differential reporting in rural and urban areas is unclear and deserves further investigation. The underlying cause of the excess mortality in late infancy likewise deserves to be investigated. Clarification of perinatal health status in rural areas would be useful in targeting programs. Programs to improve care for pregnant women might curb excess fetal deaths, while improved pediatric care could potentially reduce high mortality rates among older infants. Congress could direct the National Center for Health Statistics or the Agency for Health Care Policy and Research to investigate these issues.

*Option 23B: Develop a database that would allow Federal policymakers to target resources to States and to their rural areas with perinatal health problems.*

A number of programs have shown success in improving access to prenatal care in the past.[16] The Federal Government could build on their success by targeting resources for such programs to areas with high-risk populations, high perinatal mortality, and a high proportion of women seeking late or no prenatal care. Such areas could be identified in part with information available on vital records (e.g., birth certificates). The National Center for Health Statistics, in the Centers for Disease Control, could undertake this activity.

**Option 24: Enhance the DHHS Office of Maternal and Child Health's (MCH's) ability to provide useful information and technical support to rural maternal and infant care efforts.**

*Option 24A: Enable and encourage MCH to support additional demonstration projects in rural areas. Funded projects could evaluate the feasibility of innovative approaches to improving access to perinatal services in rural areas.*

Demonstration projects funded through MCH could be used, for example, to compare the relative cost and effectiveness of bringing providers into isolated rural areas with providing transportation services to the patients themselves. Among the current MCH-funded rural projects is an evaluation of the use of an outreach consultation team of perinatal specialists to visit rural health districts

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[16] Components of successful programs include: publicly supported obstetric providers, midlevel practitioners, perinatal transportation systems, interagency coordination, and use of outreach workers to recruit patients and provide followup and transportation.

(*37*). Demonstration project funding could be expanded to include more model projects that:

- employ nonphysician providers as rural outreach workers,
- promote regional approaches to solve access problems,
- promote linkages of available perinatal resources, and
- incorporate home visits by nurses or paraprofessionals.

Projects could be required not only to evaluate the effectiveness but the costs of these models.

*Option 24B: Provide additional funds (or earmark a proportion of future funds) to better allow MCH to offer technical assistance on request to States that are developing regionalized perinatal care services that include rural areas.*

A perinatal care network is an essential component of a functional network of comprehensive health care services to rural residents. Resources from various Federal sources are available to help States develop regional and local networks and services. Greater availability of technical assistance from MCH might help States and communities use both Federal and local funds most effectively.

### *Issues and Options in Mental Health Care*[17]

The prevalence of mental disorders in rural Americans is similar to that of their urban counterparts. Despite the similarity in mental health problems, the little information that exists suggests that rural areas have substantially fewer mental health resources than urban areas. Furthermore, where resources exist, they are likely to be narrower in scope.

As with other health facilities, mental health facilities face problems in serving populations spread over vast distances. In addition, they are caught between competing needs for services for the chronically mentally ill and services for acute and less serious conditions. Because recent Federal and State policies have tended to emphasize the former, the ability of many rural mental health providers to offer services such as suicide prevention, education, crisis intervention, support groups, and individual counseling for less severe mental health problems has waned. Furthermore, other sources of services (e.g., from nonprofit foundations) are less available to fill the vacuum in rural than in urban areas.

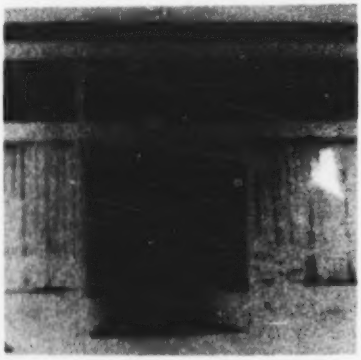

*Photo credit: Peter Beeson*

Access to local mental health services is severely limited in many rural areas.

Rural mental health professionals face problems similar to those of other rural health professionals. They have fewer training opportunities, fewer colleagues with whom to consult and to discuss professional issues, and more diverse demands on their time than do their urban counterparts. Primary care physicians provide much of the mental health care in both urban and rural areas, but they receive relatively little training in mental health diagnosis and treatment. Master's level mental health professionals, paraprofessionals, allied professionals (e.g., the clergy), and volunteers are also vital providers of rural health services.

The severe shortage of psychiatrists and doctoral-level psychologists in rural areas, the proportion of mental health care provided by nonpsychiatric physicians, and the types of services likely to be most acceptable to rural residents all suggest that *integrating mental health and other health care is especially important in rural areas*. Social workers, psychologists, clinical psychiatric nurse specialists, and paraprofessionals play an important role in extending rural mental health services to those in

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[17] See also option 12.

*Photo credit: Peter Beeson*

Staffing crisis hotlines is a possible mental health role for trained volunteers in rural areas.

need, and in linking these services with physical health services. These linkages may include such features as health and mental health clinics sharing a single service site, routine consultation between physicians and mental health center staff, or a full-time social worker providing counseling and educational services in a community health clinic or physician's office. Recent legislation has expanded the reimbursement available for certain "linkage" services, namely the mental health services provided by clinical social workers and psychologists in community health centers. Federal stimulation of linkage efforts themselves, however, has declined since the implementation of the mental health block grant in 1981.

**Option 25: Provide grants to mental health professions training programs that include rural-oriented curricula and/or train professionals most likely to locate in rural areas.**

For example, the provisions of Public Law 100-607, which provided special project grants to professional schools' training programs for clinical psychologists, could be extended to include masters' programs for social workers and clinical psychiatric nurse specialists. Or, grants under this law could be targeted or limited to projects emphasizing training for rural practice.

**Option 26: Require States to reimburse under Medicaid for mental health services provided by midlevel mental health professionals to the extent that these services are permitted under State licensure law. Reimbursement could be limited to those services that were provided in HMSAs or MUAs and would be covered if provided by a physician.**

In rural communities without psychiatrists or doctoral psychologists, primary mental health care is provided by either nonpsychiatric physicians or by midlevel mental health professionals (master's level clinical psychologists, clinical social workers, and clinical psychiatric nurse specialists). Current Federal policy covers reimbursement for the services of psychologists and social workers only in certified RHCs. Expanding the services for which midlevel mental health providers or their employers can receive reimbursement would probably increase access to these services in rural areas.

**Option 27: Encourage the development of linkages between rural health and mental health services and professionals.**

Greater enhancement of linkages might include measures to encourage case management, share building space, develop referral patterns, and make better informed decisions about patient care. "Linkage workers" could be expanded to include master's level nurse specialists. Federal initiatives of this kind are currently underway for health and substance abuse treatment, but a more permanent and consistent policy of linkages for substance abuse, mental health, and other health services could be adopted. Specific Federal strategies could include:

- reimbursement for linkage workers' services (e.g., social workers' services provided in physicians' offices, including consultative services provided to the physician);
- funding for the salaries of clinical social workers and other mental health providers in grants to federally funded C/MHCs;
- funding for inservice training, internships, and shared training sites; and
- requiring States to demonstrate that a portion of Federal mental health block grant funds is being used to support linkage efforts in rural areas as a prerequisite to continued block grant funding.

**Option 28: Invest more resources in data collection and analysis activity oriented at urban-rural comparisons of mental health and substance abuse epidemiology, and at the availability of mental health services and personnel in rural areas.**

The information available on rural mental health epidemiology and services is extremely thin and provides a poor basis for both monitoring mental health status and implementing Federal policies. Even the most basic national data on community mental health centers have been virtually nonexistent since 1981, and there are few reliable studies on mental health problems in rural areas. Congress could direct the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to place more emphasis on these research activities (e.g., through the National Institute of Mental Health's recently created Office of Rural Mental Health).

**Option 29: Encourage or require ADAMHA to fund projects intended to demonstrate the utilization of volunteers and paraprofessionals in service delivery.**

One way to help address mental health personnel shortages is to include paraprofessionals and community volunteers in service delivery. However, little is known about effective ways to increase the use of these providers, their acceptance in the community, and the effectiveness of the services they provide. Incentives to be tested in the demonstration projects could include training programs for paraprofessionals and clergy, reimbursement for professional activities to develop and train community workers, and educational support for community workers in the form of tuition for college training.

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# Child Health: A Fact Sheet

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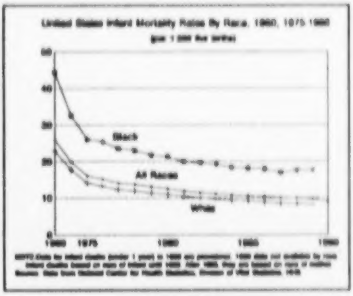
Most U.S. children are born healthy and remain healthy into their adult lives. Some children however, are vulnerable to serious illness, disability, or death. Figure 1 shows the nearly steady decline in U.S. infant mortality rates for all groups, but a persistent gap between rates for whites and nonwhites. Similar racial differences exist in incidence of low birthweight. Important influences on the health of a child are (1) early and continuous prenatal care for the mother, (2) timely immunization against vaccine-preventable diseases, and (3) routine ongoing medical care and supervision.



Mothers who receive inadequate prenatal care are more likely to have low birthweight infants (referring to infants born weighing less than 5.5 pounds) than women who receive continuous prenatal care which begins early in their pregnancies. According to the National Center for Health Statistics, about 75 percent of the babies born in this country are born to mothers who received prenatal care that began in the first 3 months of pregnancy. This proportion has been relatively stable since 1979.

Low birthweight is a leading contributor to poor pregnancy outcomes including infant death and disability in infants who survive. About 7 percent of all infants born in the U.S. are of low birthweight. Several studies have shown that the cost of prenatal care is considerably less than the cost of caring for a low birthweight infant. The Health Insurance Association of America reported that the average daily cost of care in a neonatal intensive care unit was $985 in 1989. In 1985, the Office of Technology Assessment estimated that $14,000 to $30,000 could be saved for every low birthweight birth averted.

The Department of Health and Human Services recommends that young children be vaccinated against 8 diseases between ages 2 months and 2 years. Among children entering school or enrolled in licensed child care centers, 95 percent or more are fully immunized. Estimated immunization rates drop to 70 percent for children under age 2 and may be under

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50 percent among minority preschoolers residing in urban areas. After reaching a record low of 1,497 reported cases in 1983, the incidence of measles increased sharply in the U.S. to 25,000 reported cases in 1990 when measles accounted for 61 deaths. Cases of mumps and whooping cough reported in 1990 exceeded the numbers reported for these diseases in 1983.

Some experts cite financial and organizational barriers to access to immunization services. Since 1982, the cost of a full childhood immunization series in a public clinic has increased from about $11 to over $90 per child. Public health officials do not have registries or tracking systems with which to monitor whether a child has received the recommended immunizations. Federal projects that address childhood immunization rates include subsidized purchase of vaccines and funded demonstration projects for improving vaccine coverage levels among preschool children.

Children who have a regular source of health care are more likely to receive primary and preventive health care as recommended by the American Academy of Pediatrics. Through regular medical visits, some problems can be detected and treated early and some complications of illness can be prevented. Health insurance coverage is an important factor in access to regular care. In 1990, 8.3 million children, 13 percent of all children under age 18, accounted for nearly one-fourth of this country's uninsured population. The 1988 National Health Interview Survey on Child Health showed that children in families with health insurance coverage and higher incomes are more likely to have a regular source of care than uninsured and poor children. The survey also showed that poor children are more likely to receive routine care in hospital or community clinics that in physicians' offices. The difference in source of care may reflect the relative shortage of physicians in inner city and some rural areas.

Numerous Federal grant programs help State, local and private nonprofit agencies to provide health care for children. The largest of these are Medicaid, the joint Federal/State program authorized under title XIX of the Social Security Act; nutrition programs under the Child Nutrition Act of 1966; the Maternal and Child Health Services Block Grant program authorized under title V of the Social Security Act; and the health centers that receive grants under the Public Health Service Act (PHSA). The PHSA also includes programs for lead poisoning prevention. The Administration's Healthy Start initiative funds projects to reduce infant mortality in 15 communities. A refundable tax credit helps low-income families purchase health insurance coverage for their children. Many other federally funded programs and demonstration projects provide services for improving children's health. Eligibility for some programs is restricted to low-income persons and families. Programs that do not have this explicit restriction may reach large numbers of low income children because they are directed to low-income communities or other areas in which access is limited. For many programs there is coordination at State and local levels for eligibility determination and referral to necessary services.

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# Health Care Fact Sheet: Mental Illness In The U.S.

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Nearly one in three Americans will experience a mental disorder during his or her lifetime. Mental disorders can strike cruelly, producing hallucinations, paranoia, depression, panic, and obsessions. Some people with serious mental illnesses (SMI) experience moderate problems of recent origin that never recur. Others have severe problems that continue over a long period of time. The SMI population is a heterogeneous group with different diagnoses, levels of disability, and duration of disability, and therefore, different needs. Because of these disorders, many individuals are unable to complete their education, maintain employment, or lead productive lives. The realities of mental disorders--symptoms, prevalence, and costs--demand the attention of those involved in the development and planning of necessary health, mental health, social services, housing, and disability policy.

A September 1992 survey from the Centers for Disease Control and National Center for Health Statistics indicates that there are approximately 3.3 million persons 18 years of age or older in the civilian noninstitutionalized population of the U.S. who had a serious mental illness in the 12 months preceding the survey. Approximately 2.6 million of these adults are limited by their disorder in work, school, personal care, social functioning, concentrating, and coping with day-to-day stress.

**Serious Mental Illness (SMI) in the U.S.**

| | Adults with SMI | | Adults limited by SMI | |
|---|---|---|---|---|
| Age | Thousands | Percent | Thousands | Percent |
| 18-24 | 361 | 11.1 | 291 | 11.3 |
| 25-34 | 707 | 21.7 | 501 | 19.5 |
| 35-44 | 744 | 22.8 | 600 | 23.3 |
| 45-64 | 919 | 28.2 | 749 | 29.1 |
| 65-69 | 142 | 4.4 | 99 | 3.9 |
| 70-74 | 102 | 3.1 | 82 | 3.2 |
| 75+ | 288 | 8.8 | 249 | 9.7 |
| Total | 3,264 | 100.0 | 2,571 | 100.0 |

**Source:** Centers for Disease Control/National Center for Health Statistics

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Approximately 77 percent of people with SMI saw a mental health professional in the year preceding the survey. Among those who did not see a mental health professional for their disorder, most had seen a doctor or other health professional. Many in the SMI population use prescription drugs as treatment for their illnesses. Nearly 68 percent of the SMI population who saw a doctor for their disorder used prescription medication in the year preceding the survey. Almost one-half of the people using prescription medication for mental disorders used more than one drug.

Serious mental illnesses comprise a wide range of disorders including psychoses, neuroses, schizophrenia, personality disorders, organic brain syndrome, depression, and others. The prevalence of mental disorders is high. Over 8 percent of Americans will experience a depressive illness in their lifetime. Almost 15 percent will be diagnosed with an anxiety disorder such as panic disorder or obsessive-compulsive disorder. Approximately 1.7 to 2.4 million Americans currently suffer from a persistent and severely disabling mental disorder such as schizophrenia or bipolar disorder (formerly manic depressive illness).

**Prevalence of Mental Disorders Among Adults**

| **Disorder** | **(%)** |
|---|---|
| Schizophrenia | 1.5 |
| Depressive disorders | 8.3 |
| Major depression | 5.9 |
| Anxiety disorders | 14.6 |
| Obsessive-compulsive disorder | 2.5 |

**Source:** *Estimating the Prevalence of Mental Disorders in U.S. Adults from the Epidemiologic Catchment Area Study*, Bourdon et al. National Institute of Mental Health, 1992.

The high prevalence of SMI places great demand on medical services. It also results in great costs to society. Estimates published by the Alcohol, Drug Abuse and Mental Health Administration of the Department of Health and Human Services found that mental illness posed an estimated $129.3 billion cost to the United States in 1988. Approximately 40 percent of that cost -- $51.4 billion -- arose from treatment costs. Approximately 44 percent of the cost of mental disorders to the United States--$57.1 billion--was derived from lost productivity. The psychological and social tolls on the lives of people affected by mental disorders are not quantifiable.

**Projected 1988 Costs of Serious Mental Illness (in millions of $$)**

| | |
|---|---|
| **Treatment** | **$ 51,423** |
| Support (research, training) | 3,966 |
| Morbidity (value of lost output) | 57,026 |
| Mortality (loss of earnings due to premature death) | 11,011 |
| Other | 5,838 |
| Total | $129,264 |

**Source:** *The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*. ADAMHA, 1990.

# DEBATE PROPOSITION – RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE COMPREHENSIVE NATIONAL HEALTH INSURANCE TO ALL UNITED STATES CITIZENS

# Health Insurance

## SUMMARY

In the 103rd Congress, widespread attention is being given to legislative alternatives for expanding access to health insurance. Central to the debate is the issue of how to expand access for America's estimated 35.4 million uninsured and large number of underinsured without fueling inflation in health care costs and do so at a time when significant new Federal or State spending is viewed by many as unlikely. While there is growing consensus in Congress that lack of access to adequate health insurance is a problem, there is little agreement on what, if anything, to do about it.

Some in Congress believe, for example, that the Nation can only afford gradual steps toward improving health insurance coverage, through such approaches as reform of the private health insurance market, or coverage of specific populations, such as infants and pregnant women. Others believe that the only way to address the problems of health care access and escalating costs is by enacting comprehensive reform, and establishing a program of health insurance coverage for all that incorporates effective cost controls. Whatever approach is pursued is likely to have significant effects on individuals, businesses, government, and providers and suppliers of health care, making agreement on any one or a combination of legislative proposals difficult.

Generally, the uninsured are young (under age 24); they are poor; and they have ties to the work force (primarily in small firms, in industries with seasonal or temporary employment, and in firms with a lower skilled or less unionized work force). There is evidence that the uninsured population grew in the last decade. Insurance status has implications for access to health services: the uninsured use fewer health care services and have poorer health status than the insured.

Proposals likely to be considered in the 103rd Congress incorporate widely different approaches to expanding access to health insurance, including providing tax incentives to provide coverage privately; mandating employers to extend health insurance benefits to uncovered or underinsured groups; and instituting a national health insurance system. President Clinton endorsed an employer-based approach during the 1992 campaign. He has appointed a task force that is scheduled to develop a health care reform proposal by May 1993.

One factor that may complicate a solution to access problems is the rising cost of health care. Over the past 10 years, health care spending has grown faster than spending in the general economy. Many believe that without major changes, the trend in spending will continue. The numbers of uninsured and underinsured individuals could increase as rising health care costs make it more expensive for individuals and employers to purchase coverage. Any attempt to expand access to health insurance may therefore need to address the factors fueling health care inflation. Proposals to control health care costs are incorporated in many access proposals and reflect varied strategies such as administrative reform, encouragement of managed care, and national expenditure limits enforced through controls on provider prices or insurers' premium rates or both.

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## Most Recent Developments

**President Clinton has appointed an interdepartmental task force that is scheduled to develop a health care reform proposal by May 1993. The plan offered by the President during the 1992 campaign would have required that employers provide health insurance coverage. The plan would have used a managed competition approach, along with some form of spending limits. . . .**

BACKGROUND AND ANALYSIS

## The Uninsured

According to a Congressional Research Service analysis of the Census Bureau's March 1992 Current Population Survey (CPS), in 1991 most individuals (58%) obtained insurance coverage through their own or a family member's employment. Others received coverage through public programs such as Medicare (11%) or Medicaid (8%) and 9% received coverage from individually purchased policies, CHAMPUS or other sources.

An estimated 35.4 million Americans (14%) were without any form of health insurance coverage in 1991. Nearly all the uninsured are under 65, with the greatest concentration among children and young adults. The following discussion examines the characteristics of the uninsured, some possible explanations for recent declines in coverage, and the impact of lack of coverage on access to care. (For further information on the uninsured, see CRS Report 92-432 EPW, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 1990.*)

### Characteristics of the Uninsured

**Age.** Because most senior citizens have Medicare or other retirement health benefits, nearly all the uninsured are under 65, with the greatest concentration among children and young adults. Of those under 18, 13% are without coverage; children make up nearly one-quarter of the total uninsured population. However, the rate of uninsurance peaks in the 18-24 age group; 27% of young adults are without coverage. The uninsured in this age group are often too old to be covered as dependents on their parents' policies. Those in poor families are no longer counted as part of their parents' household and may therefore be ineligible for Medicaid. Those working may be in entry-level jobs that do not provide coverage. Some of the younger uninsured may also fail to obtain insurance that is available to them, because they do not foresee the need for medical care. The rate of uninsurance declines steadily from age 25 on, chiefly because older workers are more likely to obtain coverage through their own employment.

**Employment Status.** Of Americans with health insurance, 68% receive coverage through their own employment or that of another family member. Among the uninsured in 1991, 84% had at least some ties to the work force. Nearly half were full-time workers or the dependents of such workers, but failed to obtain employment-based coverage. The uninsured are concentrated in small firms, especially those with fewer than 25 employees, in industries

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characterized by seasonal or temporary employment, and in those with a lower skilled or less unionized work force. The industries with the lowest rates of coverage are agriculture, personal services, entertainment and recreation, and retail trade.

**Income.** The uninsured are disproportionately poor. In 1991, 29% of the uninsured had family incomes below 100% of the Federal poverty thresholds, and another 12% had incomes between 100% and 133% of the poverty line. Medicaid is the major source of coverage for the low-income population. However, the maximum allowable income under Medicaid for most types of persons is below the poverty line. Also, Medicaid has "categorical" limits: some persons, such as single adults and childless couples who are neither aged nor disabled, cannot qualify regardless of income. As a result, Medicaid covered only 47% of persons in poverty in 1991.

## Trends in Insurance Coverage

Changes in the uninsured population over time are difficult to measure because of changes in standard surveys and other data problems. However, there is evidence that the proportion of the population that is uninsured rose during the early and mid-1980s. Growth in the uninsured may have occurred for several reasons. First, although the proportion of the population in the work force has been growing, the percent receiving health benefits has been dropping. Some analysts attribute this trend to shifts in employment. Many of the new jobs created in the last decade have been in the service and other nonmanufacturing industries, the sectors least likely to provide coverage. However, this factor accounts for only a small part of the growth in the uninsured.

Second, the proportion of the population receiving coverage through another family member's employment has been dropping. Several factors have contributed to this decline. As coverage of primary workers has dropped, so too has coverage of their dependents. Also, growing numbers of workers appear to be electing coverage for themselves but not for their dependents. In 1990, workers who were themselves covered through employment failed to cover their spouses in about 6% of the cases; about 8% of the children of insured workers did not receive employment-based coverage. In 1980, wholly employer-paid coverage for individuals was available to 72% of employees in medium- and large-size firms, and fully paid family coverage to 51% of employees. By 1991, wholly-paid individual coverage was available to 45% of workers, and wholly-paid family coverage to 23%. Changes have also occurred in family structure; there are more households with older children or unrelated individuals. Such family units are less likely to meet the definitions in insurance coverage rules.

Third, coverage from nonemployment sources declined, particularly Medicaid coverage. Welfare and Medicaid eligibility standards failed to keep pace with inflation; while the absolute number of people in poverty was rising, the number of people receiving Medicaid stayed relatively flat for a decade. Recent changes in the Medicaid program, such as initiatives to cover more pregnant women and children, appear to have reversed this trend. However, the full impact of these changes is not yet known.

## Implications for Access

Insurance status has implications for access to health services. The uninsured use fewer health care services and have poorer health status than the insured population. The uninsured are more likely to delay seeking care; when they finally seek care, the ailment may be more serious and costly to treat. The uninsured also rely more on emergency rooms for basic services.

While the uninsured use comparatively fewer services, they nevertheless generally do receive health care. Some of the uninsured pay for these services out-of-pocket; some receive care from clinics and facilities that receive public subsidies; and some get it from providers who are subsidizing the care through increased charges to their paying customers. For example, hospitals recorded about $12.1 billion in free care and bad debt for 1990. Much of that uncompensated care was financed by increased charges to patients with insurance.

A problem facing the uninsured is that the sources of subsidized care may be dwindling. Increasing pressures on hospitals to negotiate rates and new methods of reimbursement are making it difficult for hospitals to make up their uncompensated care costs by raising their charges to insurers or other third-party payers. Hospitals' reduced profit margins and constraints on public funding are also limiting the dollars to finance uncompensated care. If these trends continue, the access problems of the uninsured could grow more severe. The problem may be exacerbated by uncontrolled growth in health care costs. It is relatively easy to provide care when it is inexpensive, but harder to do so when that care becomes a major cost.

## Policy Options for the Uninsured

As noted earlier, while most Members of Congress agree that improving access to health insurance is a problem, there appears to be no consensus on what, if anything, to do about the problem at the Federal level. Some in Congress, for example, want to take various steps toward improving health insurance coverage through tax incentives for small businesses, reform of the private health insurance market, and/or coverage of targeted populations, such as infants and pregnant women. Others believe that the only way to address the problems of health care access and escalating costs is by enacting comprehensive reform, including a program providing universal health insurance and significant controls on health care costs. Any significant legislation that is enacted is likely to have significant effects on individuals, businesses, government, and providers and suppliers of health care, making agreement on any one or even combination of legislative proposals difficult.

Over 100 health care reform proposals were introduced in the 102nd Congress. They incorporated widely different approaches to expanding access to health insurance, including expanding health insurance coverage through Medicaid; providing tax incentives to provide coverage privately; mandating employers to extend health insurance benefits to uncovered or underinsured groups; and instituting a national health insurance system. Only one comprehensive proposal received committee action. This was the HealthAmerica bill (S. 1227) introduced by Senator Mitchell and based largely on the 1990 recommendations of the U.S. Bipartisan Commission on Comprehensive Health Care ("the Pepper Commission"). S. 1227 provided for universal health insurance coverage accomplished through a phased-in requirement on employers to provide or pay for health insurance (the so-called "play-or-pay" approach) and the creation of a public program to cover those not insured through the workplace. An amended version of this bill was ordered reported by the Senate Committee on Labor and Human Resources.

More limited, incremental proposals made somewhat greater progress. Senator Bentsen's proposal to regulate insurance underwriting and rating practices in the small group market (S. 1872) was included, with modifications, in the Senate amendment to H.R. 4210, the Tax Fairness and Economic Growth Act of 1992, and again in the Senate amendment to H.R. 11, the Revenue Act of 1992. However, the health insurance provisions were dropped in conference on both bills. The Health Subcommittee of the House Committee on Ways and Means ordered reported H. 5502 (Representative Stark), which includes regulation of insurers and a significant expansion of Medicaid coverage. The bill also established a national health budget and a Federal system for setting the rates to be paid to medical care providers by all insurers and other payers. It has been reintroduced, with modifications, as H.R. 200 in the 103rd Congress.

President Clinton has appointed an interdepartmental task force that is scheduled to develop a health care reform proposal by May 1993. The plan offered by the President during the 1992 campaign would require that all employers provide health insurance coverage; some form of financial assistance would be available to small firms as well as to uninsured individuals without employment ties. The plan would use a managed competition approach, under which individuals and small groups would obtain coverage through purchasing cooperatives, along with some form of spending limits. It is not yet certain whether the task force's proposal will retain the basic outlines of this plan.

The remainder of this section focuses on the major options considered by the 102nd Congress and likely to be reintroduced in the 103rd Congress, including both comprehensive proposals and more limited approaches.

### Universal Public Coverage

The most sweeping health insurance reform proposals would replace some or all existing public and private coverage with a comprehensive public program. These proposals take a number of different forms. **"Single payer"** plans would enroll all U.S. residents (or sometimes all but those receiving Medicare) in a single publicly funded program, replacing the multiple payers of the current system. Some proposals would establish such a program at the Federal level, while others would create State-administered programs with Federal funding. (Under some proposals, all insurance would be publicly funded, but States could give their residents a choice among private contracting plans.) **"Medicare for all"** proposals would extend the current Medicare program for the aged and disabled to cover the entire population. The major difference between this approach and the single-payer option is that Medicare benefits are less comprehensive than those included in the single-payer bills. This means that there would still be a role for private insurance in selling supplemental policies; in addition, Medicaid would still be needed to furnish supplemental coverage for the poor. A third universal coverage model -- a national health service like the British National Health Service in which the Government both finances and furnishes health care services -- has also been proposed.

A number of States (among them Florida, Hawaii, Massachusetts, Minnesota, Oregon, and Vermont) are implementing or considering their own universal coverage plans. Some proposals would change Federal law to facilitate State action. Current Federal spending on Medicare and Medicaid for State residents could be turned over for use in the State's own system. In addition, States could be permitted to regulate self-insured employer health plans (such regulation is currently preempted by the Employee Retirement Income Security Act of 1974, ERISA). Legislation could provide an open-ended authority for State systems or could create limited demonstrations.

### Employer-Based Plans

Many proposals, instead of establishing universal coverage through a public program, would build on the current system, under which most people obtain health insurance through employment. Under this approach, employers would be expected to furnish or help pay for coverage for their workers and dependents; most proposals also include expansion of Medicaid or a new public program for persons not obtaining coverage through employers. Under **play** or pay proposals, employers would provide coverage or contribute a fixed percentage of payroll towards the cost of covering their workers in a public plan. This was the approach recommended by the Pepper Commission. In the 102nd Congress, the Senate Labor and Human Resources Committee ordered reported an amended version of S. 1227, Senator Mitchell's play or pay proposal. One bill in the 103rd Congress, H.R. 727 (Matsui) would use a play or pay approach to cover pregnant women and children only).

Other proposals would mandate that employers furnish coverage, without providing the alternative of a payroll tax. This was the approach suggested by President Clinton during the 1992 campaign; some form of targeted assistance would have been available for employers who could not afford to provide coverage. Another option would simply require that employers offer coverage: that is, make a group plan available to their employees but not contribute to the premiums. In the 103rd Congress, this approach is included in H.R. 30 (Grandy); it is also a part of the Conservative Democratic Forum proposal introduced by Representative Cooper in the 102nd Congress.

## Market Reform

Some individuals or employers may wish to purchase insurance coverage but find it unaffordable or unavailable because of characteristics of the private insurance market or other factors. The final set of options would seek to make coverage more accessible or affordable. These include the following.

- Regulation of insurance underwriting practices, under which purchasers expected to incur high medical costs may be refused coverage, receive coverage subject to exclusion of payment for "preexisting conditions," or be charged higher rates than other applicants. Numerous proposals in the 103rd Congress would modify rating and underwriting practices of health insurers. These include H.R. 30, H.R. 101, H.R. 150, H.R. 191, H.R. 196, H.R. 200, H.R. 727, and S. 18.

- Promotion of group purchasing arrangements, under which small employers would join together to buy insurance, potentially increasing their bargaining power and achieving economies of scale in plan administration. This approach is included in such bills as H.R. 101, H.R. 196, H.R. 200, S. 18, and S. 223. Some "managed competition" proposals (see below) would require, rather than simply encourage, small employers to obtain coverage through State-established health insurance purchasing cooperatives (HIPCs), which would seek to contract with cost-effective insurance plans.

- Federal preemption of State mandated benefit laws. These laws, which require insurance policies to include specific types of coverage regardless of whether the purchaser desires the coverage, are alleged to increase the price of insurance. Overrides are included in most universal coverage proposals, which would replace State mandates with a Federal minimum benefit; partial overrides are also included in the insurance regulation proposals.

- Encouraging States or private insurers to develop "reinsurance" pooling mechanisms to spread the risks of high-cost cases. H.R. 101 would provide for a Federal reinsurance system in States that do not develop their own systems.

## Tax System Options

Federal tax law might be modified in a variety of ways to help more individuals purchase health insurance or to encourage more employers to provide group health plans. Some options being considered by Congress to encourage individuals to purchase coverage include: (1) liberalizing the deduction for health care costs, currently available only for costs in excess of 7.5% of adjusted gross income (see H.R. 403); (2) providing a refundable tax credit (much like the earned income tax credit) to low-income families to subsidize the cost of health insurance (see, for example, H.R. 196, S. 28, and S. 223); and (3) creating a voucher program using the Federal tax system to subsidize the purchase of health insurance by low-income families. This approach was included in President Bush's health plan.

A limited health insurance tax credit was created by the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Under the new law, a refundable tax credit is available to taxpayers for qualified health insurance expenses that include coverage for a qualifying child. Qualified health insurance expenses for which the credit is available are the premiums paid during the taxable year for health insurance coverage for children who meet certain eligibility criteria (generally the same as for the Earned Income Tax Credit). For 1992, the maximum health credit is $451.

A new tax system approach embodied in a number of proposals is the establishment of medical savings accounts (MSAs). Individual and/or employer contributions to these accounts would be excluded from income, and withdrawals to pay for medical care would also be tax-exempt. Current employer health plans might be replaced by a combination of an MSA and a limited, catastrophic health insurance plan. For example, employees might pay for the first $3,000 of medical expenses using the MSA, after which the insurance plan would be liable. Proponents contend that this would make consumers more cost-conscious while preserving catastrophic protection. MSAs are included in H.R. 101, H.R. 150, and H.R. 192.

One tax issue that has received considerable attention is the treatment of health insurance costs for the self-employed. Self-employed workers, those in unincorporated sole proprietorships or partnerships, may deduct the full cost of contributions to health plans for their employees but only a part of the cost of coverage for themselves and their families. The Tax Reform Act of 1986 established a time-limited 25% health insurance deduction for the self-employed. This deduction has repeatedly been extended; most recently, the Tax Extension Act of 1991 (P.L. 102-227) continued the 25% deduction through June 30, 1992. As passed by the Congress, H.R. 11, the Revenue Act of 1992, would have extended the deduction through June 30, 1993. However, this legislation was pocket vetoed. Many of the comprehensive health insurance proposals in the 103rd Congress, as well as several free-standing bills, would increase the deduction to 100% and make it permanent.

## Expanded Public Programs

Existing Government insurance programs, such as Medicare and Medicaid, could be expanded to reach a larger population. In addition to the "Medicare for all" plans, some proposals would expand Medicare less dramatically, by eliminating the current 24-month waiting period for benefits for some or all of the disabled, permitting early retirees to obtain Medicare coverage, or allowing unemployed workers to purchase Medicare. There are also proposals for further expansion of Medicaid, the Federal-State program for certain groups of low-income persons. In recent years, Congress has steadily expanded Medicaid eligibility for pregnant women and young children. Several proposals would further expand coverage by raising financial eligibility standards (H.R. 200) or eliminating the categorical limits that restrict Medicaid eligibility to the aged, disabled, and families with children (H.R. 191). H.R.

196 would create a new, Medicaid-like program that could, at a State's option, cover individuals up to 200% of the Federal poverty level. Medicaid expansions are also included in many of the employer-based proposals discussed earlier, in order to reach persons not covered through employment.

## Health Care Costs and Cost Containment

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other nation. U.S. health expenditures in 1990 reached $675 billion, 12.4% of GDP, as compared to 9.0% in Canada, 8.1% in Germany, 6.5% in Japan, and 6.1% in the United Kingdom. All of these countries have universal health insurance coverage and perform at least as well as the United States on standard measures of health care outcomes, such as life expectancy or infant mortality rates. There is also concern about the rate of growth in health care expenditures. Inflation in the U.S. medical sector has outpaced inflation in the rest of the economy for many years; national health spending grew an estimated 11.5% from 1991 to 1992 and is projected to grow another 12.1% in 1993, reaching a total of $940 billion. The growth in employers' health insurance costs has been even more dramatic. One recent survey of medium and large employers found that the average premium for health benefits for a single employee rose 108% between 1987 and 1992, or about 16% a year.

Many observers view the high cost of health care as a major barrier to expanded access to care for the uninsured, and there are concerns that continued inflation could either damage the competitiveness of employers who offer health benefits or lead some of those employers to reduce or eliminate benefits, further eroding access to care. For all these reasons, there is strong congressional interest in controlling health care costs, both in public programs and in the private sector. Current legislative proposals may be divided among those that focus on reducing unnecessary use of services and those that focus on how services are paid for. Some of these proposals are included in broader health reform bills intended to address both access and cost, while others have been introduced separately.

Insurance companies and public programs like Medicare and Medicaid have attempted to control medical utilization directly for many years, using outside reviewers to monitor the appropriateness of medical services. However, medical care is still very subjective. Outside reviewers may lack a firm basis on which to override the judgments of a patient's physician, and much of the variation in the way physicians practice (such as surgery rates) may be traceable to uncertainty or disagreement about what really works. In response, the 101st Congress created the Agency for Health Care Policy and Research, to perform systematic studies of how well different ways of treating a given disease or condition work. Several health insurance proposals would expand this initiative. Congress is also considering measures to address a second issue closely tied to that of utilization control: malpractice reform. The practice of "defensive medicine," performing additional tests or services in response to concerns about potential malpractice liability, is often cited as an important source of unnecessary medical care utilization. Some proposals, such as tort reforms, are aimed chiefly at limiting the size of awards to plaintiffs, while others focus on simplifying the process for adjudicating malpractice complaints. Among the bills that address one or both of these areas are H.R. 101, H.R. 150, H.R. 191, H.R. 196, and S. 223.

Another major option is reimbursement reform, changing the way hospitals and doctors are paid for their services. Medicare has led the way in this area, with its prospective payment system for hospitals (under which hospitals receive a predetermined fee for each patient) and its new fee schedule for physician services. Some health insurance proposals would give private insurers the option of paying at Medicare rates; providers would be required to accept these amounts as payment in full. Under other proposals, all public and private insurers would pay the same rates. H.R. 200 would establish a national provider rate-setting system, with rates for all payers set using Medicare-like methods. Rates would be set at levels designed to comply with a national health budget, an overall limit on the growth in health care spending.

The single-payer proposals described earlier would also use price controls to limit health spending. In addition, their proponents argue that a single-payer system could reduce the administrative costs of insurance and also of health care providers, who must now deal with the differing demands of a variety of public and private insurers in order to obtain payment. Other proposals seek to achieve similar savings in the context of a multi-payer system. For example, a number of bills would promote the adoption of uniform claim forms and "smart cards," health insurance identification cards that would carry electronically readable coverage information and perhaps medical data about the cardholder.

Finally, many insurance proposals emphasize "managed care." The prototype for managed care is the health maintenance organization (HMO). Unlike other insurers, HMOs directly provide or arrange for health services, through affiliated physicians, hospitals, and other providers; the HMO can thus control an enrollee's medical care, and may be able to provide that care with greater efficiency. Recently insurers have developed other plans that are somewhat less restrictive but still seek to manage overall patient care. Several bills would override State laws that may inhibit the development of managed-care programs; these include H.R. 101, H.R. 150, H.R. 196, and S. 18.

Several proposals, notably that of the Conservative Democratic Forum, would develop structured systems for "managed competition." Employers or other purchasers of health insurance would be grouped together in cooperative buying arrangements. Individuals participating in the arrangement would have a choice among different health care plans and would be given a financial incentive to select the least costly plan (in theory, the most efficient). The plan put forward by President Clinton during the 1992 campaign included a similar proposal, but also would have provided for a health budget and possibly premium limits as a backup cost containment approach.

## LEGISLATION

**H.R. 16 (Dingell)**
National Health Insurance Act. Provides health insurance coverage for most U.S. residents; replaces all insurance except Medicare. States and localities would administer plans with Federal assistance. Introduced Jan. 5, 1993; referred to Committees on Energy and Commerce and Ways and Means.

**H.R. 30 (Grandy)**
Universal Health Benefits Empowerment and Partnership Act of 1993. Requires most employers to offer (but not pay for) a group health plan. Assists States to develop plans for persons not eligible for employer group coverage. Preempts State mandates; extends self-employed deduction. Also includes administrative simplification and development of comparative value information programs. Introduced Jan. 5, 1993; referred to Committees on Education and Labor, Energy and Commerce, and Ways and Means.

**H.R. 101 (Michel)**
Action Now Health Care Reform Act of 1993. Regulates rating and underwriting practices in the small group market and limits use of preexisting condition exclusions. Establishes Federal or State reinsurance programs for small group carriers. Preempts State benefit mandates for small employer purchasing groups and preempts anti-managed care laws. Expands self-employed deduction. Allows tax-free employer contributions to MSAs. Also includes: administrative simplification, malpractice reform, expansion of Public Health Service programs, rural health provisions, flexibility for States in administration of Medicaid, and changes in antitrust law. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, Judiciary, and Education and Labor.

**H.R. 150 (Hastert)**
Health Care Choice and Access Improvement Act of 1993. Allows tax deduction for contributions to MSAs and for premiums for a catastrophic health insurance policy. Regulates rating and underwriting practices in the small group market. Expands self-employed deduction; preempts State anti-managed care laws. Also includes administrative simplification, malpractice reform, and provisions related to long-term care insurance. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Judiciary.

**H.R. 191 (Gekas)**
American Consumers Health Care Reform Act of 1993. Makes Medicaid acute care fully Federal and extends eligibility to all persons up to 100% of poverty; turns long-term care over to States. Taxes employer health benefits in excess of a minimum benefit package; expands self-employed deduction. Authorizes demonstrations of universal care plans. Also includes market reform, malpractice reform, and access measures. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, Education and Labor, Judiciary, and Rules.

**H.R. 192 (Gunderson)**
Farm and Rural Medical Equity Reform Act of 1993. Allows tax deduction for contributions to MSAs and for premiums for a catastrophic health insurance policy. Limits use of preexisting condition exclusions. Also includes administrative simplification and provisions related to rural health services. Introduced Jan. 5, 1993; referred to Committees on Ways and Means and Energy and Commerce.

**H.R. 196 (Houghton)**
Health Equity and Access Improvement Act of 1993. Establishes Federal/State BasiCare program to cover (at State option) persons up to 200% of poverty. Regulates insurance underwriting and rating practices in the small group market and limits use of preexisting condition exclusions in all employer plans. Preempts State mandated benefit laws and anti-managed care laws. Creates refundable health insurance tax credit and makes insurance fully deductible for individuals. Also includes malpractice reform, expansions of public health programs, and provisions related to long-term care insurance. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Judiciary.

**H.R. 200 (Stark)**
Health Care Cost Containment and Reform Act of 1993. Establishes national health budget and Federal all-payer rate-setting system based on Medicare methods; permits States to develop alternative systems. Establishes voluntary insurance plan for children, financed through premium payments. Phases in expansion of Medicaid to cover all persons below 133% of poverty and pregnant women and children below 200% of poverty. Establishes health plan purchasing cooperatives (pooled purchasing arrangements for small employers) and national outcome reporting system. Expands Medicare benefits. Expands self-employed deduction.

Regulates rating and underwriting practices and limits use of pre-existing condition exclusions for all group plans. Also includes administrative simplification, uniform data reporting, and health care fraud control. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Education and Labor.

**H.R. 403 (Solomon)**

Permits tax deduction for up to $3,000 in health insurance premiums without regard to current requirement that medical expenses are deductible only when they exceed 7.5% of adjusted gross income. Introduced Jan. 5, 1993; referred to Committee on Ways and Means.

**H.R. 727 (Matsui)**

Requires employers to provide coverage to workers and dependents who are pregnant women or children. Establishes federally funded, State administered health plans for pregnant women and children without employer coverage. Also includes small group market reforms. Introduced Feb. 3, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Education and Labor.

**S. 18 (Specter)**

Comprehensive Health Care Act of 1993. Regulates rating and underwriting practices in small group market. Preempts State mandates for employers in small employer purchasing groups and preempts anti-managed care laws. Expands self-employed deduction. Establishes commission to study health expenditure targets. Also includes provisions related to public health programs, patient self-determination, and long-term care insurance. Introduced Jan. 21, 1993; referred to Committee on Finance.

**S. 28 (McCain)**

Children's Health Care Improvement Act of 1993. Establishes refundable tax credit for health insurance expenses of children in families below 200% of poverty; the credit may be used only for school-based insurance programs established by States and localities. Also includes modifications to Public Health Service maternal and child health-related programs. Introduced Jan. 21, 1993; referred to Committee on Finance.

**S. 223 (Cohen)**

Comprehensive Health Care Act of 1991. Establishes system of voluntary health plan purchasing cooperatives for small employers, along with Federal certification of accountable health plans (AHPs) meeting reporting standards and furnishing uniform benefits set by a Federal board. Preempts State laws for AHPs; taxes employer health plan contributions in excess of lowest-priced AHP in the area. Provides refundable tax credit for individuals purchasing AHP coverage. Increases self-employed deduction. Also includes malpractice reform, access and antitrust provisions, and prescription drug cost containment. Introduced Jan. 27, 1993; referred to Committee on Finance.

## CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Bipartisan Commission on Comprehensive Health Care (The Pepper Commission). *A Call for Action*. Washington. Sep. 1990. 2 v., Final Report (S.Prt. 101-114) and Supplement (S.Prt. 101-115).

U.S. Congress. House. Committee on Ways and Means. *Health Care Resource Book*. Prepared by the Congressional Research Service and the Congressional Budget Office. Washington. Apr. 16, 1991. Ways and Means Committee Print 102-8.

----- Subcommittee on Health. *Private Health Insurance: Options for Reform*. Prepared by the Congressional Research Service. Washington. Sep. 20, 1990. Ways and Means Committee Print 101-35.

Reprinted from Health Insurance Coverage in the United States: Sources, Characteristics, and Trends, by Madeleine T. Smith, Beth C. Fuchs, and Janet P. Lundy. Washington, Congressional Research Service, 1992. p. 1-9.

# HEALTH INSURANCE COVERAGE IN THE UNITED STATES: SOURCES, CHARACTERISTICS, AND TRENDS

## INTRODUCTION AND DETAILED SUMMARY

Not since the 1970s has so much congressional attention been given to the issues of health care costs and access to coverage. By the end of the 102nd Congress, over 100 bills had been introduced in the House and Senate that would in one way or another provide for expanded financial access to health care and/or seek controls on the cost of health care. One of the factors fueling this interest is the statistical profile of insurance coverage in this country. These statistics have been used to define and pinpoint the problems, and have become an integral part of arguments for and against specific policy solutions.

This Congressional Research Service (CRS) report providing statistical data and profiling health insurance coverage in the United States was written in response to requests from committees of the Congress to aid in their health care reform deliberations. The requesting House committees included: the Ways and Means Committee's Subcommittee on Health, the Energy and Commerce Committee and its Subcommittee on Health and the Environment, and the Education and Labor Committee. From the Senate, CRS received requests from the Committees on Finance, and Labor and Human Resources.

The report is designed as a resource document, one which readers can turn to for facts and statistics regarding insurance coverage.[1] Part I provides information on public and private sources of health insurance coverage and identifies the characteristics of those persons who have and do not have health insurance. Sources of health insurance are provided by age and other demographic characteristics. More detailed information on coverage by age and employment characteristics such as firm size, industry, and labor force attachment, is presented for different types of insurance (i.e., employment based, Medicare, Medicaid, and private individual (nongroup) coverage) and for the uninsured. Retiree health coverage is also examined. In addition, an analysis of trends in coverage is provided, looking especially at the issue of whether the percentage of uninsured Americans is rising. The analysis in part I relies on data from the Bureau of the Census, March 1992 Current Population Survey (CPS), as well as the CPS for prior years.

Part II provides information on the largest sources of coverage, private health insurance, including individual as well as employer-sponsored health benefits. It begins with an overview of private health insurance, describing who sells it, and the types of financing arrangements and policies available in the current market for groups and individuals. This is followed by a more detailed look at employer-sponsored health insurance. It examines the characteristics of employers that do and do not offer coverage, alternative sources of funding for employer health plans, trends toward self-insurance, small employer pooling arrangements, and flexible benefit plans. Information is also provided on the regulation of employer-sponsored health plans. Part II includes a discussion of individual health insurance, and ends with another source of largely private coverage, State high risk insurance pools.

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[1] To assist readers, a complete list of tables and charts is included in the beginning of this report.

Readers interested in issues such as the regulation of private health insurance, and options for expanding access to coverage may wish to consult the three-part series produced by CRS in 1988: *Health Insurance and the Uninsured: Background Data and Analysis*; *Insuring the Uninsured: Options and Analysis;* and *Cost and Effects of Extending Health Insurance Coverage.*[3]

## DETAILED SUMMARY OF THE REPORT

### Part I. Sources of Health Insurance Coverage

In 1991, 86 percent of the U.S. noninstitutionalized population had some form of health insurance coverage, while 14 percent (an estimated 35.4 million people) were without any form of coverage. The uninsured were often young and poor, but many of them did have some tie to the labor force, frequently through small firms. By contrast, only 1 percent of the elderly (age 65 and over) were uninsured. Most people with health insurance had employment based coverage (65 percent of the nonelderly), while others were covered under government sponsored plans such as Medicare and Medicaid or nongroup privately purchased health insurance. Between 1979 and 1991, the percent of persons under age 65 who were uninsured increased approximately 4 percentage points, while the percent with employment based coverage declined by about 6 percentage points.

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[3] U.S. Congress. House. Committees on Education and Labor and Energy and Commerce. Senate. Special Committee on Aging. *Health Insurance and the Uninsured: Background Data and Analysis.* Prepared by the Congressional Research Service, Library of Congress. Education and Labor Serial No. 100-Z, Energy and Commerce No. 100-X, Special Committee on Aging No. 100-I. Committee Print, 100th Cong., 2d Sess. Washington, GPO, May 1988; U.S. Congress. House. Committees on Education and Labor and Energy and Commerce. Senate. Special Committee on Aging. *Insuring the Uninsured: Options and Analysis.* Prepared by the Congressional Research Service, Library of Congress. Education and Labor Serial No. 100-DD, Energy and Commerce No. 100-BB, Special Committee on Aging No. 100-O. Committee Print, 100th Cong., 2d Sess. Washington, GPO, Oct. 1988; U.S. Congress. House. Committees on Education and Labor and Energy and Commerce. Senate. Special Committee on Aging. *Costs and Effects of Extending Health Insurance Coverage.* Prepared by the Congressional Research Service, Library of Congress. Education and Labor Serial No. 100-EE, Energy and Commerce No. 100-C, Special Committee on Aging No. 100-P. Committee Print, 100th Cong., 2d Sess. Washington, GPO, Oct. 1988.

Specifically, analysis of the health insurance status of the U.S. noninstitutionalized population in 1991 shows the following:

**Health Insurance Coverage and Population Characteristics**

- Whites were most likely to have health insurance (88 percent), while Hispanics were least likely (67 percent).

- Persons living in the Midwest and Northeast were more likely to have health insurance (88 percent) than those living in the South and West (80 and 82 percent, respectively).

- Sixty-eight percent of the poor were insured compared with 91 percent of individuals with family income at least two times the poverty level.

- Only 12 percent of the poor received health coverage through an employer, while 51 percent had either Medicare or Medicaid.

**Employment Based Coverage**

- Employment based coverage varied by labor force attachment. Among the nonelderly, about 80 percent of full year, full-time workers and their dependents had employment based coverage, while 28 percent of part year, part-time workers and 34 percent of their dependents had employment based coverage.

- Employment based coverage also varied by earnings. Among workers under age 65, about 26 percent of those workers earning approximately the minimum wage had employment based coverage, compared to 62 percent of those earning between $9,000 and $19,999 and 87 percent of those earning $30,000 or more.

- Over 90 percent of the spouses and children of workers with employment based coverage also had this type of coverage. Still, 3 percent of spouses and children were uninsured, accounting for approximately 7 percent of the uninsured population in 1991.

- Employment based coverage varied by firm size and industry. About 85 percent of workers and dependents in large firms (1,000 or more employees) had employment based coverage compared to 36 percent of workers and their dependents in small firms (1-9 employees). Approximately 90 percent of those working in public administration had employment based coverage compared to 27 percent of those working in agriculture/forestry/fisheries.

- Among retirees, 57 percent of those under age 65 reported employment based coverage compared to 32 percent of those age 65 and older.

### Individual/Nongroup Insurance

- Private individual (nongroup) health insurance is more common among two groups: those without attachment to the labor force or whose employer does not offer health insurance coverage and the elderly who purchase private nongroup coverage to supplement Medicare.

### Medicare and Medicaid Coverage

- Among persons 65 years and older, 96 percent had Medicare and less than one percent were uninsured.

- The greatest proportion of Medicaid recipients under age 65 was found among those not in the labor force: 39 percent of the heads of insurance units[3] with no attachment to the labor force and 63 percent of dependents with no attachment to the labor force received Medicaid. Only 4 percent of dependents of full year, full-time workers received Medicaid.

- Half of those receiving Medicaid were children, with 20 percent under 5 years, and 30 percent between 5 and 17 years. Almost half of the Medicaid population was white, while close to one-third was black. Almost two-thirds (63 percent) of those covered by Medicaid came from families with incomes below the poverty level.

### The Uninsured

- Uninsured rates varied by age and sex. Females were less likely to be uninsured among persons age 18 to 34, but more likely to be uninsured among persons age 60 to 64.

- Uninsured rates also varied by age and race/ethnicity. The percent uninsured was higher for Hispanics in each age group than for whites or blacks, and the percent uninsured was higher for blacks than for whites. Almost one-half (45 percent) of Hispanics ages 18 to 24 were uninsured, as were 39 percent of Hispanics ages 25 to 34.

- Employment characteristics were related to lack of insurance. Among workers, 13 percent of those with full year, full-time attachment to the labor force were uninsured, compared to 37 percent of those with part year, part-time attachment. In small firms (1-9 employees), 37 percent of workers and 25 percent of their dependents were uninsured compared to 9 percent of workers and 5 percent of their dependents in large firms (1,000 or more employees). Thirty-five percent of those working in personal services industries were uninsured compared to 4 percent among those working in public administration.

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[3] An insurance unit comprises the policyholder and dependents (if any) who would be eligible for dependent coverage under typical insurance rules. See appendix A for more detail.

- Persons who lacked health insurance coverage were not representative of the population: the uninsured were overrepresented among young adults, the poor, blacks and Hispanics, those with less than full-time jobs, and those who worked for small firms.

### Trends in Insurance Coverage

- Trends in health insurance coverage from 1979 to 1991 show that the percent with employment based and private nongroup coverage declined over time, while the percent with Medicaid or Medicare and the percent uninsured increased.

- From 1979 to 1986, the population under age 65 increased by 16 million persons. If coverage rates had not changed over this period, population change would have produced 13 million more persons covered under various types of coverage, and if uninsured rates had not changed, 3 million more would have been uninsured. Decreasing rates of coverage and increases in uninsured rates meant instead that only about 8 million more persons were covered and 8 million more were uninsured.

- Decreases in rates of employment based and private nongroup coverage between 1979 and 1986 produced about 3 million fewer persons with employment based coverage and about 3 million fewer with private nongroup coverage than would have been covered if rates had not declined.

- From 1987 to 1991, the population under age 65 grew by 8 million persons. If coverage rates and uninsured rates had not changed over this period, population change alone would have produced about 7 million more persons with coverage and about 1 million more uninsured. Decreases in coverage rates and increases in uninsured rates meant that only about 4 million more persons were covered and 4 million more were uninsured.

- Decreases in employment based coverage rates between 1987 and 1991 meant that about 7 million fewer persons had employment based coverage than would have been covered if rates had not declined. Increased coverage rates under Medicaid lessened the effect of decreased employment based coverage rates, and kept the number uninsured from rising even further.

**Part II. Private Health Insurance**

Private health insurance is the largest source of health benefits coverage, covering about 183 million Americans, or 73 percent of the population in 1991. In contrast, public coverage (including Medicare, Medicaid, military health care, and veterans' health care) covered about 63 million Americans, or 25 percent of the population. With respect to private health insurance, the report points out the following:

- The sources of private coverage include about 1000 commercial insurance companies (covering about 92 million persons in 1989); 73 Blue Cross and Blue Shield plans (covering about 73 million); and other plans (covering 77 million), including self-insured plans, self-administered plans, plans employing third-party administrators (TPA), and about 550 health maintenance organizations (HMOs) (which covered about 34 million persons). Many HMOs are operated by the Blues or commercial insurers. (The total of these numbers is greater than the number covered by private health insurance because some individuals have more than one policy from more than one source.)

- Several types of arrangements are used to pay for and, under some systems, to provide health care services. These include traditional, fee-for-service plans, which pay for services of the enrollee's choice of health care provider for each service rendered (covering 62 percent of enrollees in employer-sponsored group health plans in 1990), and network-based managed care arrangements, which include a network of providers from which enrollees receive health care services. Network managed care arrangements include HMOs (20 percent of enrollees), preferred provider organizations (13 percent), and point of service (POS) programs (5 percent).

- A variety of types of private health insurance coverage exists, including medical expense insurance, which pays for medical bills or services such as hospital and medical expenses (83 percent of group premiums paid to commercial insurers in 1989), dental expenses (8 percent), Medicare supplemental costs (3 percent); and disability income insurance, which pays for lost income while disabled (6 percent).

- About 61 percent of Americans (152 million persons) have group coverage sponsored by their employers, and about 12 percent (30 million persons) have individual (nongroup) coverage purchased directly from insurers.

***Employer Sponsored Group Health Insurance***

Over 61 percent of the population (152 million) is covered by employer-sponsored group health insurance plans. However, not all employers offer health benefits and, when benefits are offered, not all employees accept them.

Certain characteristics are predictive of whether an employer will offer insurance. According to a 1990 survey of employers:

- *Size*. Only 27 percent of the smallest firms (fewer than 10 employees) offer health benefits, whereas 98 percent of those over 100 offer coverage.
- *Type of industry*. Government entities and manufacturing firms are the most likely to offer coverage; retail trade firms are the least likely to do so.
- *Location*. Employers in the South are least likely to offer coverage; those in the Northeast are most likely.
- *Use of low-wage workers*. Only 19 percent of firms in which 50 percent or more of the workers earn less than $10,000 annually offer health benefits compared to 56 percent of all firms in which less than half of the workers earn less than $10,000.
- *Use of full-time workers*. Of firms offering health benefits, only 20 percent had a workforce in which less than three-fourths of the employees were full-time, compared with 34 percent for firms not offering benefits.
- *Employee turnover*. Only 30 percent of firms with a rate of turnover exceeding 50 percent offered health benefits, compared with 52 percent of firms with less turnover.
- *Legal organization*. Sixty percent of incorporated firms and 26 percent of unincorporated firms offered health benefits.

Firm size, type of industry, and the like are really proxies for other characteristics of a business that may affect its willingness or ability to offer insurance. At the core of its decision is the price of insurance. A firm's assessment of whether it can afford to offer coverage and, if so, whether it needs to do so to attract and retain employees is largely based on price. As the cost of health insurance continues to grow steadily higher, fewer firms may offer coverage. This may be at the root of the trend discussed above of decreases in the percentage of the population covered under employer plans.

Employers electing to offer health benefits do so through a variety of arrangements. Once most common, fully insured health plans are found primarily in small firms. In addition to benefit payments, the cost of fully insured plans reflects the insurer's profit and overhead, State mandated benefits and premium taxes, and sometimes a State risk pool assessment. To reduce premium costs and increase plan flexibility, many companies turn to self-insurance. Today, approximately 65 percent of firms self-insure and somewhere between 50 to 56 percent of employees participate in self-insured health plans. As late as 1980, only about 34 percent of firms were self-insuring.

Self-insured plans can be administered entirely by the employer, or by an insurer or other entity. While self-insurance is most practical for large firms, the availability of stop loss policies to cover very large claims has made self-insurance increasingly attractive to even the smallest of firms. But with the growth in self-insurance has come a decline in consumer safeguards. State regulators have no jurisdiction over employer plans; they are only able to regulate the insurance sold to employers. Self-insured plans are regulated only under Federal law which does little to protect enrollees from plan insolvencies, benefit cuts, or terminations.

A relatively recent development affecting health benefits is the appearance of flexible benefit plans (or "flex plans") as part of employer sponsored fringe benefit packages. Flex plans permit employees with different family responsibilities to tailor their benefits to their own needs. They give employers a mechanism with which to set overall cost limits on their benefit offerings, especially important in respect to health care. By providing nontaxable benefits, flex plans also enable employers to increase their employees' after tax income without paying higher wages. In 1989, 24 percent of full-time employees working for medium and large firms were eligible for flex plans, up from 5 percent in 1986.

While most insured workers obtain health benefits through a single employer health plan, some are covered through various types of multiple employer arrangements. Included among these are multiple employer welfare arrangements (MEWAs), which are generally health plans offered to the employees of two or more employers by a third party, such as a trade association. MEWAs are used to pool small employers into larger units to make health insurance more affordable and administratively simple. Bringing together a number of small firms into one pool, it is argued, can produce administrative economies, such as reduced marketing, that will be reflected in lower premiums than if each firm sought coverage independently. Several factors may work against such savings, however. One is that insurers still tend to review the insurability of each of the member firms of the multiple employer group.

### *Individual (nongroup) Health Insurance*

Private individual (nongroup) coverage covers a much smaller proportion of the population than employer group coverage. Approximately 12 percent of the U.S. population (or about 30 million individuals) had individual insurance in 1991. The report describes the following features of individual coverage:

- For about 60 percent of those with individual coverage, such coverage was their only source of insurance; the rest had such coverage in addition to some other type of coverage.

- Individuals purchase nongroup coverage when they have no employer-sponsored coverage or they are self-employed; for temporary periods when they are between jobs or recently retired but not yet Medicare-eligible; or to supplement other coverage they may have.

- Individual coverage differs from group coverage primarily in the greater degree to which its applicants are underwritten, i.e., evaluated by the insurer to determine the degree of risk the applicant represents. Individuals with existing medical conditions are less likely to be accepted for coverage under a nongroup policy than a group policy.

- In 1987, about 65 percent of nongroup enrollees were covered by commercial insurers, about 30 percent by Blue Cross and Blue Shield, and about 5 percent by HMOs.

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# Medicaid: Financing, Trends, and the President's FY 1993 Budget Proposals

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## SUMMARY

Medicaid is a Federal-State matching entitlement program providing medical assistance to certain low-income persons. Mirroring the rapid increases in health care spending generally, Medicaid is one of the fastest growing items in both Federal and State budgets. Federal spending for Medicaid is expected to increase by 38 percent between fiscal years 1991 and 1992 and by another 16.5 percent in FY 1993. President Bush's FY 1993 budget proposes to limit growth in "mandatory" programs but would make only modest changes to Medicaid totalling $104 million in savings. Enactment of the President's legislative proposals would reduce Federal Medicaid spending from the $84.5 billion projected under current law to $84.396 billion in FY 1993.

## BACKGROUND

Medicaid, permanently authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to approximately 30 million low-income persons. Every State except Arizona participates in the Medicaid program, as do the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. (Arizona currently provides federally funded medical assistance through a demonstration program that has received waivers of certain Medicaid requirements.) Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. At the State level, Medicaid is administered by a designated single State agency. Federal oversight of the Medicaid program is the responsibility of the Medicaid Bureau in the Health Care Financing Administration (HCFA) within the Department of Health and Human Services.

Traditionally, eligibility for Medicaid has been linked to receipt of benefits from the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) program. Recent changes in Federal Medicaid law have extended eligibility to target populations who may previously have been uninsured for health expenses. States are now required to cover pregnant women and children up to age 6 with household incomes up to 133 percent of

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the Federal poverty level, and children aged 6 to 19 and born after September 30, 1983 in families with incomes up to 100 percent of the poverty level. States also are required to pay premiums, deductibles, and coinsurance for low-income enrollees in Medicare, the Federal program for the aged and disabled. At the State's option, other medically needy persons may be covered.

States are required to provide certain basic services such as hospital, physician, or preventive and primary health care services for children. States may elect to cover additional services such as prescription drugs, dental care, or podiatry. Within statutory guidelines, States are free to develop reimbursement methodologies and payment levels for covered services.

## Medicaid Financing and Spending

The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. The formula provides a higher Federal matching rate to States with lower per capita incomes. By law, matching rates range from 50 percent to 83 percent of a State's expenditures for services. Matching rates for administrative costs vary by expenditure category, rather than by State; they are generally 50 percent but may be as high as 90 percent for specific items. The Federal share of Medicaid accounts for about 57 percent of total program expenditures and is appropriated from general funds.

Because Medicaid is an entitlement program, appropriations do not wholly govern the amount spent. Participating States are entitled to receive payments from the Federal Government to cover the Federal share of outlays for services; individuals who meet Medicaid eligibility requirements are entitled to have States pay for medically necessary covered services provided to them. Medicaid spending is determined by the number of beneficiaries, the benefits offered, and the amount of reimbursement for services. There is no limit on Federal Medicaid payments to States.

Under the Budget Enforcement Act of 1990 (BEA) (Title XIII of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508), Medicaid spending is subject to "pay-as-you-go" rules governing entitlement programs. The budget law requires that for fiscal years 1991 through 1995 any legislative changes must be at least deficit neutral. Medicaid legislation that would increase spending must be offset by spending reductions in Medicaid or other entitlement programs, or by revenue increases. Other factors that influence Medicaid spending, such as economic downturn or changes in States' eligibility rules, are not affected by BEA.

Medicaid is one of the fastest growing items in both Federal and State budgets. Following an increase of 27.8 percent from FY 1990 to FY 1991, the Office of Management and Budget (OMB) projects that Federal Medicaid outlays will increase by 38 percent between fiscal years 1991 and 1992 and by another 16.5 percent in FY 1993. These percentage increases are associated with Federal spending levels of 52.5 billion in FY 1991, and projections to $72.5

billion in FY 1992 and $84.5 billion in FY 1993. Total Federal-State Medicaid spending is estimated at $92.1 billion in FY 1991 and projected to reach $127 billion in FY 1992.

According to the OMB, the number of Medicaid beneficiaries has increased from 23.5 million in 1989 to 30 million in 1992; the program is projected to serve 31.5 million in 1993. The sharp increase in expenditures is only partly due to increases in caseload. Other factors in the growth include general increases in health care costs, increases in reimbursement rates for Medicaid services, and special payments to hospitals. State programs that leveraged taxes and donations to obtain more Federal funds for Medicaid are responsible for a part of the recent growth. Several States levied special assessments on Medicaid providers, usually hospitals, or accepted donations from them. Used as a portion of a State's share of Medicaid expenditures, revenues from providers generated Federal Medicaid matching payments. Some States then repaid the providers their donations plus the Federal funds. Other States used the increased Federal funds for general Medicaid spending. These State financing mechanisms were curtailed by P.L. 102-234 which (1) requires that levies be broad-based (uniformly imposed) and (2) caps the proportion of State Medicaid spending that can be financed by revenues from providers.[1]

## FY 1993 BUDGET

Legislative proposals in President Bush's budget are projected to reduce Federal Medicaid costs by $104 million to $84.396 billion in FY 1993. The reduction represents the net impact of proposals to finance Medicaid survey and certification activities through user fees, increase private health insurance collections for some children, and encourage AFDC recipients to undertake entrepreneurial activities to achieve self-support through self-employment. The table below summarizes their budget impact.

**TABLE 1. Impact of Budget Proposals on FY 1993 Federal Medicaid Outlays**
**($ in thousands)**

| | |
|---|---|
| Total Federal payments, current law | $84,500,234 |
| Legislative proposals | |
| Survey and Certification Fund | -99,000 |
| Net impact of medical child support enforcement and AFDC plan for achieving self-support (PASS) | -5,000 |
| Total Federal savings | -104,000 |
| Net Federal outlays | $84,396,234 |

Source: President's FY 1993 budget.

---

[1] The law describes a tax as uniformly imposed if the amount, rate, and/or base for the tax is the same for all subject providers, and the tax does not provide for credits, deductions or exclusions that have the effect of refunding all or a portion of the tax.

### Survey and Certification Fund

For the third consecutive year, the President's budget proposes to create a HCFA revolving fund to cover all costs of survey and certification activities in Medicaid (and Medicare). Nursing facilities and certain suppliers participating in the Medicaid program are subject to at least annual survey and certification procedures. States are responsible for conducting inspections to determine whether providers can be certified as meeting the standards and conditions for Medicaid participation. The Federal matching rate to States for survey and certification activities is 75 percent. Under the proposal, each provider or supplier requesting Medicaid certification would pay an annual user fee as a condition of participation. Fees deposited into the revolving fund account would be available to pay all Federal and State survey and certification costs as well as associated HCFA administrative expenses. This change would make survey and certification activities self-supporting in conformance with the precedence set for certification of clinical laboratories.

Current Medicaid law requires States to pay hospitals and nursing facilities rates that are reasonable and adequate to meet the costs incurred. User fees would be additional allowable costs that are reimbursable by Medicaid when payment to a facility is made on the basis of costs incurred. Savings from the change would be the net difference between financing survey and certification through user fees, and reimbursing the providers' costs. The proposal is estimated to result in a net Federal saving of $99 million in FY 1993.

### Encourage Entrepreneurship

All AFDC recipients must be covered by Medicaid. A proposal in the President's FY 1993 budget for AFDC could, if enacted, increase the number of AFDC recipients and subsequently increase Medicaid costs. President Bush proposes a plan for achieving self-support (PASS) for AFDC recipients. To promote entrepreneurial activities by AFDC recipients, the President proposes to permit States to exclude some income and resources from calculations of AFDC eligibility. Exclusions would be available for recipients who developed, and obtained approval of a plan to achieve self-support through self-employment. Under PASS, families whose "excess" income and resources would have made them ineligible for AFDC could retain AFDC and Medicaid benefits. The President's budget does not include more detail about PASS.

### Improve Medical Support Enforcement

A child who is covered by Medicaid may also be covered by private health insurance that is carried by a parent who does not have custody of the child and is not in the same household. The Administration proposes to strengthen medical support enforcement and require States to ensure that noncustodial parents' health insurance, instead of Medicaid, provides medical support for their children.

The projected combined impact of proposed legislation to encourage entrepreneurship among AFDC recipients and to strengthen medical child support is $5 million in FY 1993.

## Other Proposals

In addition to the specific proposals described above, the President's FY 1993 budget mentions a need to supplement the pay-as-you-go rules of the Budget Enforcement Act with a mechanism to restrict the "automatic" growth of entitlement programs. Without projecting savings from the Medicaid program in particular, the Administration says there would be "enormous" savings if mandatory programs were permitted to grow only with changes in the population and the consumer price index.

One other item in the Administration's budget that could affect Federal Medicaid spending is a proposal to replace funding for individual programs with a consolidated block grant to States. According to the Administration, a similar proposal made in the FY 1992 budget has been modified following consultation with representatives of State and local governments.

To increase the flexibility that State and local governments have in managing their programs, the Administration proposes to consolidate a number of programs into a block grant. Medicaid administrative expenses, estimated at $2.6 million in FY 1992 and $2.8 million in FY 1993, is among 19 program candidates that the budget lists for inclusion in a block grant. Other candidates include State administrative expenses for the AFDC and Food Stamp programs. This part of the Administration's proposal parallels a proposal for block grant consolidation that was made by the National Governors' Association (NGA) in April 1991. At that time, the NGA expressed support for a pilot project in 5 to 10 States for consolidated grant administration of AFDC, Food Stamp, and Medicaid administrative expenses. For block grants in general, the NGA requested funding guaranteed over 5 years at levels agreed to among the States, Congress, and the Administration. The Administration proposes to phase in a block grant over a 5-year period using a funding formula that would approximate current funding distribution levels to individual States.

# MILITARY HEALTH CARE/CHAMPUS MANAGEMENT INITIATIVES

## SUMMARY

While costs of the Military Health Services System (MHSS) as a whole have increased significantly in recent years, the costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)--a constituent part of the MHSS--have skyrocketed. The reasons for these sharp increases include (1) a larger number of beneficiaries, (2) higher usage rates, (3) greater per capita costs, (4) start-up costs of new management initiatives, (5) expenses created by new technologies, (6) higher beneficiary expectations, and (7) a benefit structure that encourages inefficient use of certain services. Other issues besides costs have confronted Congress and Department of Defense (DOD) administrators. These include beneficiary dissatisfaction, the budget process, and the role of Congress in overseeing these health care programs.

In order to reduce cost growth and otherwise improve management of the MHSS, DOD has proposed creating a system of coordinated care. In essence, this system will create a "health network" approach to encourage patient use of military hospitals and preferred civilian networks (who share the risks for unit cost and volume). In addition, Congress has taken action to address many of the current problems. These include the enactment of laws that provide for (1) placing separate limits, cost-sharing and deductibles on CHAMPUS mental health benefits; (2) increasing the individual and family CHAMPUS deductibles for most dependents and retirees; (3) expanding DOD's authority to collect from third-party insurers for services provided at Military Treatment Facilities (MTFs); (4) requiring better management of reforms; and (5) limiting reductions in medical personnel levels and facilities.

These initiatives and changes in the MHSS may have a number of important implications. First, local commanders will need substantial training to interface with civilian providers in competitive health care environments. Second, risk-sharing and increased deductibles are politically contentious. Third, while many of these changes are justified in terms of bringing benefits in line with what is currently available in the civilian sector, reducing the attractiveness of these benefits may have an effect on recruiting and retaining quality personnel. Fourth, limits on CHAMPUS mental health care may be viewed as arbitrary and medically unjustified. Fifth, pursuing third-party insurers could be viewed as forcing the private sector to assume DOD's responsibilities. Sixth, by not including Medicare in the coordinated care concept, it is possible that this policy, coupled with military budgetary limitations, may have the effect of forcing those over 64 years of age out of the MHSS and into Medicare.

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# MILITARY HEALTH CARE/CHAMPUS MANAGEMENT INITIATIVES

## INTRODUCTION

The costs of the Military Health Services System (MHSS), as a whole, have increased significantly in recent years. Within this system, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), has experienced even more dramatic cost growth. CHAMPUS is the Department of Defense's equivalent of a civilian health insurance plan. In fiscal year (FY) 1985, the cost of the CHAMPUS program was $1.36 billion.[1] By FY 1989, it had risen to $2.74 billion--a 101 percent jump.[2] In order to pay for the cost increase, Congress has provided the Department of Defense (DOD) with either (1) supplemental funds (additional to amounts stipulated in regular annual DOD appropriations acts) or (2) authority to transfer funds from either DOD programs. To gain a greater measure of control over cost growth, both Congress and DOD have undertaken a number of initiatives which may have an impact on the delivery of health care services.

This report briefly describes CHAMPUS, its background, and its role in the overall Military Health Services System. It also examines some of the major issues facing MHSS administrators and congressional oversight committees, as well as the steps being taken by key players to strengthen and improve the program. Further, the report comments briefly on some of the broad economic, military, and political implications of recent, and possible future, changes. It does not discuss specific CHAMPUS or MHSS coverage for individual care.

### Background

The primary mission of the Military Health Services System (MHSS) is to maintain the health of military personnel so that these personnel can carry out their missions and to be prepared to deliver health care during time of war. In support of those in uniform, the military medical system also provides, where available, health care to active duty dependents, retirees and retirees' dependents. Hereafter, the use of the term "dependents" refers to the dependents of both active duty and retired personnel unless otherwise stated.[3]

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[1] U.S. Department of Defense. Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), CHAMPUS Chartbook of Statistics, Aurora, CO, Dec. 1985: III-3.

[2] U.S. Department of Defense. Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), CHAMPUS Chartbook of Statistics, Aurora, CO, Aug. 1990: III-3.

Health care for retirees and dependents has always been considered a somewhat ancillary function of the military health care system. Prior to 1956, the statutory authority to provide health care to retirees and dependents was not clear.

The Dependents' Medical Care Act (Public Law 84-569; June 7, 1956; 70 Stat. 250) described and defined retiree/dependent eligibility for health care at military medical facilities as being on a space available basis. Thus, for the first time, the dependents of active duty personnel were **entitled** to health care at military medical facilities on a space available basis. Authority was also provided to care for retirees and their dependents at these facilities **(without entitlement)** on a space available basis. This legislation also authorized the imposition of charges for outpatient care for such dependents as determined by the Secretary of Defense. Although no authority for entitlements was extended to retirees and their dependents, the availability of health care was almost assured given the small number of such persons. Therefore, while not legally authorized, for many the "promise" of "free" health care "for life" was functionally true. This "promise," it is widely believed, was and continues to be a useful tool for recruiting and retention purposes.

On September 30, 1966, Congress passed the Military Medical Benefits Amendments, 1966 (P.L. 89-614; 80 Stat. 862). As explained in a subsequent committee report:

> . . . Congress recognized "The Fading Promise" to retired military personnel, as well as the plight of dependents of active duty members who were located away from military medical facilities and passed the CHAMPUS program to be effective the first day of 1967. This legislation also resulted from the comparatively disadvantageous position in which the military dependents and retirees were placed, with Federal government employees [sic] health plans blossoming profusely, while the ability of military facilities to provide health care for all concerned was diminishing.[4]

Specifically, this 1966 legislation authorized:

> (1) an expanded hospitalization program and a new outpatient program [in civilian facilities] for dependents of [personnel in] the uniformed services on active duty;

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[3] See the Glossary at end for a description of eligible dependents.

[4] U.S. Congress. House. Committee on Armed Services, Subcommittee No. 2, CHAMPUS and Military Health Care, 93rd Cong., 2nd Sess. Washington, D.C., Dec. 20, 1974: 12.

> (2) a new hospitalization and outpatient program [using] civilian sources for retired military members, their spouses and children, and the spouses and children of deceased retired members and of deceased active duty members;
>
> (3) an expansion of care in military hospital facilities for all categories of dependents, to include treatment for nervous and mental disorders and chronic conditions; and,
>
> (4) a specialized program of financial assistance for members of the uniformed service on active duty whose spouse or children are either mentally retarded or physically handicapped.[5]

In effect, CHAMPUS became and remains the military equivalent of a health insurance plan, run by the DOD for the dependents of active duty personnel, military retirees and the dependents of retirees, and unmarried dependent children or unremarried spouses of deceased service personnel or retirees. Active duty personnel, who receive all their care via Military Treatment Facilities--MTFs, are not eligible to receive health care coverage under CHAMPUS. Retirees remain eligible to receive CHAMPUS benefits until they become eligible to receive Medicare (Part A) -- usually at age 65.

Initially, CHAMPUS was designed to provide benefits equivalent to those available to Federal employees under the Blue Cross/Blue Shield high option plan. Unlike private insurance plans, CHAMPUS does not require the payment of monthly premiums by beneficiaries.[6] Congress has made relatively few changes in the CHAMPUS program during its first two decades.[7]

While eligible beneficiaries may receive medical care at military facilities, this care is not always available because of limited space or limited types of services provided at the particular location. Another restricting factor might be the long distance a beneficiary would have to travel to reach a facility. CHAMPUS has provided cost-sharing benefits (both CHAMPUS and the beneficiary sharing responsibility for the payment of care received) for covered benefits received from civilian health care providers (subject to CHAMPUS regulations). One of those regulations says that if beneficiaries need non-emergency **inpatient** care and live within certain ZIP codes (catchment areas) surrounding the military medical facility (or a 50-mile radius in Europe), they must first seek **inpatient** care at that military medical facility and must have a signed document (nonavailability statement) stating that inpatient care was not available at that military facility before CHAMPUS will cost-share their inpatient care at a civilian facility. A nonavailability statement does not mean that CHAMPUS will pay for health care outside the military medical services system -- the care received must also be covered by CHAMPUS. Nonavailability statements are not required for outpatient services provided under CHAMPUS. Although the military encourages beneficiaries to utilize military sources of health care, there is no requirement that they do so. Because of the variety of sources of care, it is difficult to predict who (retiree or dependent) will receive outpatient care and where (CHAMPUS or MTF) this care will be provided.

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[5] U.S. Congress. Senate. Armed Services Committee, 89th Cong., 2nd Sess., S. Rept. No. 1434. Washington, D.C., GPO.

[6] For a more in depth discussion of CHAMPUS rules and benefits, see U.S. Department of Defense, OCHAMPUS, CHAMPUS Handbook, Aurora, CO, July 1990.

[7] Changes that were made included broadening the definition of eligible dependents; former spouses were later included, for example.

Under CHAMPUS, beneficiaries pay part of the costs of allowable medical care received. The amount paid depends on a number of factors including the beneficiary's status (dependent of active duty member, retiree, or the dependent of a retiree), the type of care received (inpatient or outpatient) and whether or not the physician or hospital accepts CHAMPUS assignment.[8] In the latter case, the payer/beneficiary is reimbursed by CHAMPUS only for CHAMPUS-allowable charges and services, which may vary from those actually billed. Providers who participate in CHAMPUS agree to accept the CHAMPUS "allowable charge" as their full fee. In certain areas, the availability of programs under the CHAMPUS Reform Initiative may affect health care costs (see CRI in the Glossary).[9]

Under cost-sharing provisions, CHAMPUS pays a proportion of "reasonable" charges. Since CHAMPUS pays a proportion and not a fixed amount, increases in medical costs in the civilian sector equate to increased payments by CHAMPUS and possibly the beneficiary, even though the percentage paid remains the same. Beneficiaries must pay a deductible before CHAMPUS begins to cost-share.

Protection against the potentially financial catastrophic results of care were implemented to limit the out-of-pocket expenses of beneficiaries. On October 1, 1987, "catastrophic caps" were placed on CHAMPUS to limit annual out-of-pocket expenses. The limits for active duty families and retiree families are $1,000 and $10,000 per year, respectively.[10]

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[8] Health care providers who participate in CHAMPUS, or accept assignment, agree to accept the CHAMPUS allowable charge (including any cost share and deductible) as the full fee. For a discussion of fees, deductibles and cost-sharing, see U.S. Department of Defense, CHAMPUS Handbook, Aurora CO (updated annually).

[9] CHAMPUS Reform Initiative -- a program aimed at reducing medical costs to both beneficiaries and the government through the use of discounted health care to patients who choose from a pre-approved list of doctors who have agreed to limit their charges.

[10] P.L. 100-180; Dec. 4, 1987; 101 Stat. 1019.

In recent years, CHAMPUS administrators and congressional oversight committees have been confronted with a number of problems and issues. The most significant of these, undoubtedly, is cost growth. This issue as well as several other key concerns are discussed in greater detail in the following section.

## MAJOR ISSUES

### Costs

As the number of retirees and dependents has increased, so has the cost of operating CHAMPUS. In addition, those who live near military facilities have often been forced to use CHAMPUS because of a lack of available space or a lack of services at these facilities. Finally, the shortage of military medical professionals has also forced many retirees and dependents to turn to CHAMPUS rather than seek more cost-effective care at a military facility.

When originally enacted in 1966, the House Armed Services Committee (HASC) estimated that the cost of running CHAMPUS in its first year would be $142 million (actual first year cost: $166 million). As reported almost ten years later:

> . . . costs increased at an alarming rate, so that in FY 1975 the CHAMPUS budget was $509 million, an increase of 300 percent over the 1966 cost.[11]

In FY 1985, costs reached $1.4 billion and by FY 1989 the total costs were $2.7 billion. From FY 1967 through FY 1989, total Federal outlays (controlling for inflation) grew by 89 percent: CHAMPUS spending for this same period grew by 361 percent. In other words, CHAMPUS spending in constant dollars increased at a rate nearly four times that of Federal outlays (see Table 1 on the following page). Overall medical cost increases in the military (direct care and CHAMPUS) have been roughly equivalent to those seen in the civil sector. According to the Assistant Secretary of Defense for Health Affairs, Enrique Mendez, "(O)f note is the fact that the military's rate of health care cost growth has tracked the civilian rate very closely for the last several years. Indeed, the military health costs have risen at a slightly slower rate than the civilian costs since 1985: 55% compared to almost 58%."[12]

The reasons for these rapid increases in costs are numerous. First, the number of eligible beneficiaries has increased substantially. The number of retirees and their dependents has increased from 2.4 million in 1964 to 3.2 million in 1974[13] to nearly 6.2 million in 1990.[14] Currently, there are a total of 9.2 million military medical beneficiaries (including active duty personnel and retirees over 65 who are not eligible for CHAMPUS). The number of CHAMPUS-eligible beneficiaries is approximately 6 million.

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[11] U.S. Congress. House. Committee on Armed Services, 1974: 15.

[12] Mendez, Enrique, Assistant Secretary of Defense for Health Affairs, 77th Interagency Institute for Federal Health Care Executives, Washington. D.C., Sept. 17, 1989: 9.

[13] U.S. Congress. House. Committee on Armed Services, 1974: 4.

[14] Mendez, 77th Interagency Institute, Washington. D.C., Sept. 17, 1989: 13.

Second, health care is being used with greater frequency. From FY 1984-FY 1988 the number of outpatient visits covered by CHAMPUS increased from 4,578,111 to 8,558,455. During this same period, the number of hospital days increased from 2,215,885 to 2,639,632. It is notable that during this same period the average length of stay actually decreased from 7.8 to 7.3 -- more admissions for shorter stays.[15] In part, the increase in the utilization rates of health care is due to the aging of the military beneficiary population. Older beneficiaries tend to have higher admission rates to hospitals and may displace younger beneficiaries at Military Treatment Facilities (MTFs). CHAMPUS per capita costs have increased from $213 in FY 1985 to $432 in FY 1989.[16]

**Table 1.**
**Total CHAMPUS Costs for Selected Years***
**(In current $ millions)**

| | |
|---|---|
| 1965 | $166 |
| 1970 | 280 |
| 1975 | 509 |
| 1980 | 712 |
| 1985 | 1371 |
| 1987 | 1963 |
| 1989 | 2755 |
| 1990 | 3182 |

* Data from 1970. 1980, 1985, 1987, 1989 and 1990 are from OCHAMPUS and may differ slightly from those data reported elsewhere.

The fact that these CHAMPUS-eligible beneficiaries may use military health care facilities "places a squeeze on active duty families, operational missions of ... military facilities and staffs often result(ing) in scaled back capabilities and interruptions in care."[17]

Third, in some cases, cost growth can be attributed to a decrease in work load at military medical facilities: military facilities may not have sufficient staff personnel, or may be shut down entirely. Eligible dependents who are unable to receive care at military medical facilities turn to the more expensive CHAMPUS plan. The availability of medical professionals can be acutely affected by incidents such as the Persian Gulf war where large numbers of military medical personnel are deployed, leaving only a limited number of personnel at home to care for active duty personnel. In the long run, the mobilization of medical reservists to take the place in MTFs of deployed personnel (i.e., backfill) may have helped to alleviate medical personnel shortages at MTFs that would otherwise have caused beneficiaries to be diverted to CHAMPUS.

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[15] See CHAMPUS Chartbook, March 1989: VI-23, VI-15, and VI-19.

[16] See CHAMPUS Chartbook, Aug. 1990: IV-17.

[17] Mendez, Enrique, Assistant Secretary of Defense for Health Affairs, CHAMPUS Reform Initiative Executive Conference, U.S. Naval Training Center San Diego, CA, Oct. 25, 1990.

Fourth, during recent years, new initiatives designed to restrain costs have caused cost increases in the short run. Start up costs include, but are not limited to, funds spent for administrative changes, education and public awareness, as well as contracting. These initiatives are generally designed to restrain cost growth and are not expected to reduce costs but rather curtail the rate of cost growth.[18]

Fifth, technological improvements generally increase (not decrease) overall health care costs. Expensive testing procedures, such as Computerized Axial Tomography (CAT scans) and Magnetic Resonance Imaging (MRIs), boost costs. Procedures or therapies that increase longevity for certain illnesses without curing the illness may also increase costs. This is true in the case of the drug AZT and AIDS, for example.

Sixth, increased patient expectations also have acted to boost costs. Today's patients are better informed and expect to benefit from a broad array of sophisticated and costly medical services.[19]

Seventh, the benefit structure of CHAMPUS and military health care is more generous than that available in the civil sector. This generosity has encouraged use above and beyond the rate in the civil sector in certain areas such as mental health. For example, it was found that the structure of these benefits provided an incentive to use costly inpatient care, even when outpatient care would be more appropriate.[20]

Illegal activities have not been reported to be significant contributors to increasing costs. Few cases of fraud or abuse have been detected, and measures have been adopted to avoid them. According to the CHAMPUS Office of Program Integrity, which monitors reports of fraud and abuse, 297 cases were finalized (investigated and closed) in 1989.[21]

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[18] For example, the U.S. Comptroller General reported that by using contracting strategies (e.g. Project Restore) "CHAMPUS costs will be reduced by $43 million in fiscal year 1990 after an expenditure of about $25 million [start up costs] on the projects." U.S. Comptroller General, General Accounting Office, Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals, GAO/HRD-90-131, B-240715, Sept. 7, 1990: 29.

[19] See Mendez, 77th Interagency Institute.

[20] Lewin/ICF, Analysis of CHAMPUS Mental Health Policies, Submitted to: Department of Defense Health Affairs Health Program Management, June 7, 1990.

[21] See CHAMPUS Chartbook, Aug. 1990: IV-21.

**Beneficiary Dissatisfaction**

A second area of concern is beneficiary dissatisfaction. Because military personnel are reassigned routinely, and because the availability of medical care services varies from location to location, services available at a previous assignment may be unavailable, or available to a lesser extent, at the current assignment. Comparisons tend to highlight current "deficiencies." This does not mean that this care is perfect or absolutely deficient. Instead, it emphasizes the psychological effect of relocation and variations in care available. Ironically, although most service members, retirees, or their families can describe problems they have encountered, many are interested in expanding the availability of care via DOD.[23]

Many of the complaints against CHAMPUS are specific in nature and would be viewed as "problems" in other health care programs. These are:

- finding physicians who accept CHAMPUS payments;
- non-coverage of experimental procedures;
- late reimbursement to physicians or beneficiaries;
- not all physician "mandated" care is covered (some patients believe that a nonavailability statement is a voucher for services they received to be covered by CHAMPUS);
- "high" out-of-pocket expenses. (Although there are catastrophic caps to limit out-of-pocket expenses, medical costs can be a significant portion of a family's budget.)

Many of these problems are the result of a lack of understanding of what benefits are available.

Dissatisfaction, however, can be a healthy means of acknowledging where deficiencies may exist. The growth in demand, for example, has itself created management problems in that it has become difficult to deal efficiently with an expanding population of beneficiaries who themselves are using CHAMPUS at a greater rate. These problems create administrative delays in the services rendered by CHAMPUS. While beneficiaries continue to receive care, reimbursement has been delayed significantly. In order to expedite claims processing, CHAMPUS has contracted with civilian insurers such as Blue Cross/Blue Shield to process claims more efficiently.[23]

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[23] U.S. Congress. House, Committee on Armed Services. Military Personnel and Compensation Subcommittee, Hearings, Military Medical Care, 100th Cong., 1st Sess., HASC Rept. 100-48, Washington, D.C., 1987.

## Role of Congress

Since Congress influences and has some level of control over military health care, complaints are directed to political leaders for "corrective action." Congress has a difficult role when compared to policymakers in the private health care sector. Few private insurance Chief Executive Officers (CEOs) can be voted out of office by their policyholders -- they are answerable only to their shareholders. Most private care insurers or providers are primarily concerned with the economics of providing care -- what can be provided, at what cost/profit, etc. Congress is faced with the reality that many military members, retirees and dependents *believe* that military health care is free and guaranteed for life. While this latter assumption in not true in terms of entitlements actually authorized by statute, this still tends to color the reform debate. Congress must address both the economics and politics of providing care. Thus, for Congress, the decision of what care to provide, who may receive this care, how it is delivered, and so on is often influenced by expectations and economic (as well as medical) concerns. A decision may be politically sensible, but economically or medically controversial. Conversely, other programs or issues may themselves be politically problematic -- Medicare catastrophic care or abortion. Therefore, Congress is in a position, vis-a-vis CHAMPUS oversight, that is quite different from the position of those managing private or even other public health care programs.

In addition, military health care has a role in a larger context -- national defense. Congress needs to consider that the nature of military service and the burdens it places on service members and their families is arguably different from those in civilian employment situations. The types of health care services available to members of the armed forces are often justified in terms of the unique role of the armed forces in general, as well as the unique role of health care in the context of the military.

## Budget Process

Finally, the budget process itself has created problems in recent years. In budgetary terms, CHAMPUS is an account to which funds are annually appropriated, but which incurs obligations as benefits are used. It is important, therefore, that the amount of money requested and appropriated closely match the expected costs of these benefits. According to the House FY 1991 Authorization report: "The DOD has repeatedly failed to include adequate funding for CHAMPUS in budget submissions ... The committee, therefore, directs the Secretary of Defense to ensure that future budget submissions are based on an accurate projection of utilization rates and reflect a realistic estimate of the true cost of the CHAMPUS program."[34]

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[23] See U.S. Congress. House. Committee on Armed Services, Hearings, Military Medical Care, 100th Cong., 2nd Sess. HASC Rept. 100-122, Washington, D.C., 1989.

Direct responsibility for these budget problems can be attributed, in part, to both the Department of Defense and Congress. A pattern seen in the budget process in recent years is as follows:

- DOD submits a budget apparently not able to precisely project who will receive care, where, or from whom; the budget represents an underestimate, given the enormous growth rate in the program;
- Congress underfunds this budget;
- By the fourth quarter of the FY, CHAMPUS is out of funds;
- DOD approaches Congress for supplemental funding;
- Congress provides transfer authority, supplemental appropriations and/or DOD carries over costs to the next fiscal year;
- Supplemental appropriations, the reprogramming of funds from other DOD programs, or carryovers are used to cover CHAMPUS obligations.

According to the U.S. General Accounting Office, CHAMPUS budget shortfalls from fiscal year 1985 through 1989 totalled $1.8 billion. Table 2 shows the budget shortfall in each of these years as well as the method employed to finance each fiscal shortfall. Underestimating, underfunding, carryovers, supplemental appropriations, and transfer authorities have tended to obscure and delay solutions to these budgetary problems.[35]

**Table 2.**
**How CHAMPUS Shortfalls Were Financed, FY 1985-89**
**($ millions)**

| | | *Financing Method* | | |
|---|---|---|---|---|
| Fiscal Year | Budget Shortfall | Reprogramming | Supplemental appropriation | Carryover to next year |
| 1985 | 27.3 | -- | -- | 27.3 |
| 1986 | 360.0 | 100.0 | 260.0 | -- |
| 1987 | 610.7 | -- | 425.0 | 185.7 |
| 1988 | 529.0 | 529.0 | -- | -- |
| 1989 | 252.0 | 152.3 | -- | 99.7 |

*Source: U.S. GAO, Funding Shortfalls:* 10.

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[34] U.S. Congress. House. Committee on Armed Services, National Defense Authorization Act for Fiscal Year 1991, H.R. 4739, 101st Cong., 2nd Sess., House Rept. 101-665, Aug. 3, 1990: 297.

[35] See U.S. Comptroller General, General Accounting Office, Funding Shortfalls in CHAMPUS, GAO/HRD-90-99BR, B-231236, Mar. 19, 1990.

## WHAT IS BEING DONE?

### "Coordinated Care"

In 1990, Assistant Secretary of Defense for Health Affairs (ASD/HA) Enrique Mendez proposed creating a system of coordinated care to address many of the problems confronting the delivery of DOD health services.

Under the present system, there are nearly 9.2 million eligible beneficiaries. It is currently impossible to predict who will seek medical treatment, and where (Army, Navy -- Marine Corps, Air Force -- including Primus and Navcare facilities, Uniformed Service Treatment Facilities, CHAMPUS, Medicare, VA, or other third-party insurers including HMOs, PPOs -- see Glossary) they will seek it. For this reason, the cost of providing care is an uncertain obligation. Under this initiative, which received congressional approval, care will be coordinated in order to "control the rate of growth in military health care costs and improve the quality of health benefits." It is expected that this coordinated care system will create a health care system that is managerially sound, eliminate uncertainty of cost and demand, and introduce accountability to health care operations. In addition, this system "does not pass on to military beneficiaries the significant increases in health care costs."[36]

In essence, this system will create a "health network" approach which encourages patients to use military hospitals and preferred civilian networks who share the risks for unit cost and volume.

Nine steps will be taken:[37]

(1) Health care management will be integrating via closer coordination among the services, CHAMPUS and alternative civilian provider networks. In other words, instead of being managed separately, these provider networks will, to the extent possible, be brought together under a more centralized management arrangement.

(2) MHSS users will be enrolled in a local coordinated care system consisting of military and civilian health care resources.

(3) Local commanders will competitively contract with networks of effective, quality civilian doctors and hospitals. When demand exceeds supply at the MTF, these networks linked to military hospitals will be used, and patients guided only to that level of care necessary and appropriate.

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[36] See Mendez, Enrique. Remarks to Military Coalition Conference, Air Force Association Building, Rosslyn, VA, July 20, 1990: 9.

[37] See Mendez, 77th Interagency Institute, 1990.

**(4) Patients will select a primary care entry point in this network whose doctors and nurses will be responsible for insuring appropriate care in the correct setting.**

**(5) The military hospital should always be the first choice to treat CHAMPUS-eligibles if care is available. (In FY 1988, of the 129 military hospitals in the U.S., 121 had occupancy rates at or below 70 percent. At the same time, about 70 percent of CHAMPUS costs were being incurred within MTF catchment areas.)[28]**

(6) The nature of CHAMPUS will change:

- CHAMPUS will be a financier of care and not an alternative delivery system.
- CHAMPUS will have to improve as a financier
  - physician reimbursements need improvement.
  - prevailing rates will be paid (CHAMPUS pays on average 43 percent above what medicare pays).
  - quality control and utilization management will be improved.
- One benefit will be modified -- inpatient mental health
  - Residential Treatment Centers (RTC-see Glossary) for adolescents and inpatient psychiatric care increased by 127 percent from 1986 to 1989. Mental health accounted for 25 percent of the total CHAMPUS budget in FY89 (see Table 3).

(7) CHAMPUS will provide greater support to local commanders and administrators in dealing with sophisticated and competitive local health care markets.

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[28] See also U.S. Comptroller General, GAO, Defense Health Care: Potential Savings. Sept. 7, 1990.

### Table 3.
### Top Ten Inpatient Diagnoses Ranked by Government Cost for Care Received in FY 1989

| ICD-9-CM Diagnosis Code | Description | Government Costs ($ millions) |
|---|---|---|
| 296 | Affective psychoses | $155.7 |
| 300 | Neurotic disorders | 66.7 |
| V30 | Single liveborn | 63.8 |
| 312 | Disturbance of Conduct, not elsewhere classified | 61.8 |
| 650 | Delivery in a completely normal case | 50.2 |
| 414 | Other forms of ischemic heart disease | 34.3 |
| 313 | Disturbance of emotions specific to childhood and adolescence | 30.9 |
| 309 | Adjustment reaction | 28.2 |
| V22 | Normal pregnancy | 26.1 |
| 765 | Disorders relating to short gestation and unspecified low birthweight | 23.2 |
| **Total** -- Top Ten Diagnosis Codes | | $540.9 |
| **Total** -- All Diagnosis Codes | | $1,433.1 |
| Top Ten as a Percent of All Codes | | 37.7% |

**Source:** U.S. Department of Defense, CHAMPUS Chartbook, August 1990: IV-15.

(8) CHAMPUS will establish new standards to judge efficiency and effectiveness of providing health care and hold local commanders accountable.

(9) CHAMPUS will educate the consumer. Beneficiaries need to understand that in a managed care system there are trade-offs in terms of absolute freedom to choose the source of health care vs. limited access, quality, continuity of care and possible financial incentives.

It is expected that these changes will be implemented immediately while others will be implemented over a period of years.

**Legislative Initiatives**

The FY91 DOD Authorization Act,[29] as amended by the Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act of 1991,[30] included a number of provisions concerning health care. Many of these provisions are a direct result of issues discussed above.

Recognizing the extraordinary increase in mental health care costs, provisions in the law relating to CHAMPUS were changed so that inpatient psychiatric care was limited to 30 days per year for patients over 18 years of age, and 45 days for patients under 19 years of age (with waivers allowed in certain situations). For those seeking admission, Congress stated that a mandatory preauthorization of inpatient care would be required. Recognizing civilian practices in this area, it was also considered appropriate that separate deductibles, cost-sharing, and catastrophic caps be implemented for mental health care.

In addition, Congress capped care at a residential treatment center (RTC) at 150 days per year with the possibility of a waiver for extraordinary cases. Mental health benefits provided by DOD have been very generous. The creation of these new policies would bring DOD care in line with care available in the civilian or private sectors.

Congress prohibited DOD from reducing the number of medical personnel (endstrengths), without justification, as a result of the reduction or draw down of military personnel in general. The availability of military medical personnel should keep health care costs down by allowing eligible beneficiaries to receive care at military facilities rather than via CHAMPUS or other more expensive options.

The skyrocketing increase in CHAMPUS costs has prompted Congress to legislate an increase in the CHAMPUS deductible from $50 and $100 for individuals and families, respectively, to $150 and $300. In the case of a dependent or family of an enlisted member below pay of E-5 pay grade, the deductibles remain at $50 and $100, respectively. While the tripling of these deductibles may seem dramatic, it is important to note that they have not increased since their creation in 1966. In fact, the new rate is less than what they would be had they been indexed to inflation, and it is less than the 1990 rate for Federal Employee Health Benefit Plan-FEHBA BC/BS upon which they were originally modeled. Currently, the BC/BS deductible is $200 per person, two family members paying $200 maximum each for the family deductible, and $50 per inpatient admission.

Congress also expanded DOD's authority to collect from third-party insurers for services provided at MTFs. The Authorization Act expands the current collection authority to include outpatient, as well as inpatient care. In addition, collections may also be made from Medicare supplemental coverage to the extent that such payments would have been made had Medicare been used.

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[29] P.L. 101-510; Nov. 5, 1990; 104 Stat. 1485.

[30] P.L. 102-25; April 6, 1991

Congressional concerns over the implementation of the CHAMPUS Reform Initiative (CRI, see Glossary) prompted language that set conditions to be met before the program was authorized to expand. These conditions include (1) that CRI should show itself to be more cost effective than CHAMPUS or any other health demonstration project being conducted by the Secretary, (2) that the contractor selected to underwrite the delivery of health care under CRI should accomplish the expansion without disruption to CHAMPUS beneficiaries or delays in the processing of claims, and, (3) that the contractor should be able to financially underwrite CRI, both currently and in the future. Further, the Comptroller General and CBO will be required to submit a report within 30 days of the Secretary's certification evaluating that action.

Language was also included that will require a closer look at Uniformed Service Treatment Facilities (USTF). The House Armed Services Committee restated its interest in the feasibility of making USTFs integrated members of a managed care model. From FY82 through FY88, costs to DOD for care received at these facilities increased at an extraordinary rate. The USTFs are former Public Health Service Facilities that were initially authorized to provide care to members/beneficiaries of the uniformed services at the same cost (rate) beneficiaries would pay at MTFs. Some USTF agreements have since been modified to allow for payments under CHAMPUS terms. This designated status has been continued while awaiting a report from the Secretary. Should the Secretary find that more cost effective care is available elsewhere in the geographic region, this designation would be terminated. Otherwise, it is expected that these facilities would become members of a managed care model. Lacking receipt of this report, Congress has extended the designated-status termination date to December 31, 1993, capped funding of these facilities, provided the Comptroller General with the authority to examine records at these facilities and required the Comptroller to audit these facilities during FY89 and FY90 (with particular attention paid to funds and the source of funds for lobbying efforts by these facilities).

Also, Congress required that the Secretary concerned must submit to Congress a report before any Military Treatment Facility is closed or downgraded (except in the case of a base closure). This report must address (1) the reason for the action, (2) the projected savings to the Government, (3) the impact on CHAMPUS and Medicare in the catchment area, (4) the impact on beneficiary cost-sharing, (5) alternative ways to provide care to the beneficiary population that would not result in an adverse impact on this population, and (6) an explanation of how care would be provided and at what costs to the beneficiary population.

The House Armed Services Committee has noted its annoyance at the problems concerning CHAMPUS budget submissions and has directed the Secretary to ensure that future budgets are based on accurate projections of utilization rates and reflect a realistic estimate of the true cost of the CHAMPUS program.[31]

The House committee has stated its pleasure with and support of the coordinated care program (outlined above) and intends to monitor DOD's progress in achieving its goals.

Finally, the House committee encouraged DOD to continue in its efforts concerning health promotion.[32] It is believed that these efforts will yield greater benefits to personnel and their families as well as result in cost savings to the Department.

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[31] U.S. Congress. House. National Defense Authorization Act for Fiscal Year 1991: 297.

[32] Health promotion activities include educational program intended to provide beneficiaries information and services that lead to a healthier lifestyle. Smoking cessation, weight control, exercise and nutrition, and drug/alcohol abuse programs are examples of health promotion activities.

## ASSESSMENT

As a result of the above initiatives, a number of results may be anticipated. First, local military health care commanders will have greater control of the health care delivery system and can take steps to ensure that needed care is provided efficiently and economically within the parameters of local resources. Local commanders will be given control over the budgets for health care (including MTFs and CHAMPUS). However, military managers will need substantial training to interface with civilian/community level providers in competitive environments. Legal, contracting, and political issues are predictable as Military Treatment Facilities become active players in the local civilian marketplace.

Second, risk sharing arrangements, increased deductibles, caps on services provided, and separate deductibles for mental health care are likely to be viewed by beneficiaries as an erosion of earned benefits. Such changes are politically contentious.

Third, many of these reforms are being justified in terms of changes in the civilian sector brought about largely by the same concern over cost increases. However, the military services recognize that health care benefits are an integral element in their ability to attract and retain personnel. Justifying changes on the basis of the civilian sector (and making DOD benefits more comparable to what is found in the civilian sector) might have an adverse effect on recruiting and retention.

Fourth, health care providers view the restrictions on care coverage and caps, particularly in the case of mental health, as arbitrary and artificially limiting the amount of care that may be required. They argue that this creates an implicit tax on the provider and possibly the patient.[53]

Fifth, expanding DOD's collection authority to a broader range of third-party payers is likely to generate additional revenue. However, private insurers note that their premiums are based on the fact that a certain proportion of their population will receive health care from the military (for free). Forcing third-parties to pay will increase premiums for all those covered by private providers. In essence, changes in the military health care system can effect those individuals and payers not affiliated with DOD. Private insurers view the expanded pursuit of third-party payment as an unfair method of legislatively forcing private industry to assume DOD's responsibilities.[34]

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[53] According to testimony submitted before the House Subcommittee on Military Personnel and Compensation, April 24, 1991, Bryant Welch, Executive Director of Practice for the American Psychological Association, stated "... (O)ur experience with governmental agencies (such as CHAMPUS...) involved in health care delivery is that they not only consistently underestimate both the overall consumption and the cost of providing such services but also intensify overall costs by ineffective, cost intensive review programs." Arguably, differences in consumption and compensation, as well as additional costs as a result of review must be paid, at least in part, by the provider who may view it as an implicit tax on services provided.

Conversely, collecting from third-party insurers may be viewed as receiving benefits already paid for by the beneficiary and/or his/her employer. Arguably, it is unfair to provide a windfall to these insurers at the taxpayers expense.

Sixth, some have raised a question of age discrimination. Nowhere in the legislation nor in the Assistant Secretary of Defense's proposal is it stated that age should be used as a method of deciding how care is delivered. However, it is possible that those over age 64 will be excluded from the MHSS network. As noted above, military retirees who become eligible for Medicare (usually at age 65) lose their entitlement to CHAMPUS. Persons over age 65 incur much larger than average health care expenses.[35] It is argued that given limited budgets, military health care commanders could seek to exclude the 65+ population from the MHSS, thus forcing them to seek care from Medicare. Forcing this population to Medicare (which can be more expensive for the beneficiary), would likely:

1. Keep military costs down;

2. Keep military hospital space available for those who might otherwise be forced to use CHAMPUS; and,

3. Keep military medicine directed toward a "young and vigorous" force.

Retirees contend that it would be better if all sources of health care coverage -- including Medicare -- were made a part of the military Coordinated Care network. It is argued that by including Medicare, health care received at an MTF could be billed to Medicare under "Medicare subvention funding."[36] In this way, the military commander would not assume the cost of caring for those eligible for Medicare, and the retiree would continue to have the option of receiving care at an MTF. In addition, the true support provided by the MTF would be recognized. It can be argued that if subvention funding were allowed, administrative costs resulting from coordination between the two programs would increase. Since receiving care at an MTF is cheaper than at private facilities, allowing for subvention funding may actually result in savings for the Medicare. In other words, health care provided by DOD could be cheaper for Medicare than the same care provided in the private sector and billed to Medicare. However, military provided care for Medicare-eligibles currently provides a windfall to Medicare. Therefore, should subvention funding be allowed, it is likely that Medicare outlays would increase. These Medicare costs would, arguably, increase to a greater extent if Medicare-eligible retirees were turned away from military health care and forced to receive care in the private sector via Medicare.

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[34] Congress expanded collection for hospitalization in 1985 under the Omnibus Budget Reconciliation Act. The insurance industry opposed the expansion "saying it would force companies to raise premiums." (Smith, Paul, Services to Start Collecting for Hospitalization, Army Times, Sept. 29, 1986, 22). Such increases in premiums would affect both the companies and non-military policy holders. For a more detailed discussion, see U.S. Congress. House. Committee on Armed Services, Collection from Third-Party Payers of Costs of Certain Medical Care Provided in Facilities of the Uniformed Services, 98th Cong., 2nd Sess., House Rept. 98-751, May 15, 1984.

[35] DOD patients who are in the age group 65-74 use twice as many bed days per year than patients 45-64. By the time a patient reaches age 75, he uses four and one-half times as many hospital bed days per year. By the year 2000, DOD conservatively projects the number of persons over age 65 who are eligible for care in military hospitals will exceed 1.5 million. That is four times more than the number of those eligible in 1980, and approaches twice the 910,000 who are eligible today. See: Mendez, Enrique, 77th Interagency Institute: 6.

Faced with limited budgets, the need to attract CHAMPUS patients to MTFs, and the expense of providing care for those over age 64 who may otherwise be sent to Medicare, some commanders might opt to use MTF spaces for CHAMPUS-eligible beneficiaries and refer those over 64 to Medicare.

Finally, the ability of DOD and Congress to reform the situation of the MHSS must be considered. Politically, this issue is troublesome. Members of Congress are faced with (1) a military medical budget that is skyrocketing--in spite of efforts to slow its growth, (2) a growing constituency (military active duty/retirees/dependents) demanding their "promised" benefits, and (3) a budget deficit and political atmosphere that makes cuts in the overall military budget necessary.

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[36] Military members pay Social Security taxes that entitle them to Medicare coverage. Medicare subvention funding is a term used in proposals to allow the DOD to bill Medicare when DOD provides health care service to medicare-eligible beneficiaries.

## GLOSSARY

*CAM* -- Catchment Area Management, a precursor of coordinated care in which hospital commanders control both direct care and CHAMPUS dollars to expand medical care at their hospitals or to discount health care from local providers.

***CHAMPUS*** -- Civilian Health and Medical Program of the Uniformed Service, a health benefits program for certain dependents of active duty personnel, retirees, and their dependents (as well as certain others) of the uniformed services.

***CHAMPVA*** -- Civilian Health and Medical Program of Veterans Affairs, a medical benefits program through which the VA helps pay for medical services and supplies obtained from civilian sources by eligible dependents and survivors of certain veterans.

***Coordinated Care*** -- a major initiative which marries the direct care and CHAMPUS systems. Under this initiative, a "health network" of providers is utilized with local commanders being given greater responsibility for access to and the cost of health care.

***CRI*** -- CHAMPUS Reform Initiative (also known as CHAMPUS Prime-a DOD HMO, and CHAMPUS Extra-a DOD PPO), a program aimed at reducing medical costs to both beneficiaries and the government through the use of discounted health care to patients who choose from a pre-approved list of doctors who have agreed to limit their charges.

***DEERS*** -- Defense Enrollment Eligibility Reporting System, a nationwide computerized data bank which lists all active duty and retired military members, and which also include their dependents. Active duty and retired service members are listed automatically, but these members must list their dependents and report any changes to family members' status (divorce, adoption, etc.). CHAMPUS claims processors check DEERS before processing claims, to make sure patients are eligible for CHAMPUS benefits.

***Dependents*** -- For a member or former member of the uniformed services, a dependent is defined as 1) the spouse; 2) the unremarried widow(er); 3) the unmarried legitimate child (including adopted child or stepchild) who is either a) under 22 years of age, b) incapable of self-support because of physical or mental incapacity that existed before the disqualifying birthday and dependent on the member or former member for at least one-half of his support, or c) under 24 years of age and enrolled in a full-time course of study as approved; 4) a parent or parent-in-law residing in the residence and dependent upon the member or former member for at least one-half of his support; and, 5) certain former spouses (see Burrelli, David F., Military Benefits for Former Spouses: Legislation and Policy Issues, Congressional Report 89-187F, March 20, 1989.

***DRG*** -- Diagnostic-related groups, a new way of paying civilian hospitals for inpatient care under CHAMPUS. They are effective in 49 states, the District of Columbia and Puerto Rico -- only Maryland is exempt. Under DRGs, CHAMPUS pays most hospitals a fixed rate for inpatient services, regardless of how much the care actually costs.

***HMO*** -- Health Maintenance Organization, a health insurer that provides covered services directly or pays for covered services only when furnished by a network of affiliated providers.

***MHSS*** -- Military Health Services System, a generic term used to describe the many facets of health care made available by the Department of Defense including Military Treatment Facilities and CHAMPUS.

***MTF*** -- Military Treatment Facility (also referred to as uniformed service hospitals), includes all military hospitals and former Public Health Service hospitals now called "Uniformed Service Treatment Facilities."

***PPO*** -- Preferred Provider Organization, a network of civilian health care providers who agree to provide care at fixed or reduced rates.

***PRIMUS*** -- Walk-in clinics run by civilians under Army contracts (NavCare is the Navy version of Primus).

***Project CARE*** -- Coordinate Appropriate Resources Effectively (CARE), a program under CHAMPUS, as directed by Congress, to conduct an expanded Home Health Care (HHC) Demonstration as a part of an individualized case-management range of benefits. This program is designed to provide less expensive alternatives to long term and repeated hospitalization for beneficiaries with chronic and catastrophic health problems requiring medically complex care.

***Project IMPRINT*** -- Former name of the CHAMPUS Reform Initiative. The term Project IMPRINT is no longer in use.

***Project RESTORE*** -- A major initiative made up of a number of components including the Partnership Program in which local community civilian providers treat CHAMPUS patients in military hospitals at a discount from their normal charge; and, the Alternate Use of Champus Funds Test under which each military service can use up to $50 million of its CHAMPUS funds for projects that use military hospitals to treat CHAMPUS patients.

***Residential Treatment Centers*** -- RTCs are centers that provide long-term treatment for children or adolescents suffering from serious mental disorders.

***USTF*** -- Uniformed Service Treatment Facilities (See MTF), formerly Public Health Service hospitals in Baltimore, MD; Boston, MA; Seattle, WA; Portland, ME; Cleveland, OH; Houston, Galveston, Port Arthur, and Nassau Bay TX; and Staten Island, NY.

***USVIP*** -- Uniformed Services Voluntary Insurance Program, an insurance program offered by Mutual of Omaha Insurance Co. designed to provide former members and certain former spouses with temporary coverage.

Reprinted from Veterans' Programs: Major Legislation and Issues in the 102d Congress: Issue Brief, by Anne Stewart and Mary F. Smith. Washington, Congressional Research Service, Updated Regularly. p. 2-5.

## Health Programs

The VA provides health care to eligible veterans in its own facilities -- 171 VA hospitals, 129 nursing homes, 354 outpatient clinics, and 35 domiciliaries. Care is also provided through VA contractual agreements with non-Federal facilities, such as community hospitals and nursing homes and on a grant basis in State veterans' home facilities. Certain dependents and survivors of veterans are eligible for VA medical care under the Civilian Health and Medical Program (CHAMPVA). Care for dependents and survivors is generally provided in non-VA facilities.

Current eligibility requirements for veterans' inpatient hospital and nursing home care were established in 1986 by P.L. 99-272, as amended by P.L. 101-508 in 1990. The VA is required by law to furnish free hospital care and may furnish free nursing home care to veterans in the "mandatory care" category. Veterans in the mandatory care category include veterans with service-connected disabilities; former prisoners of war; certain veterans exposed to Agent Orange or atomic radiation; veterans disabled as a result of VA treatment; pre-World War II veterans; veterans receiving cash assistance under the VA's income-based pension program; veterans eligible for the income-based Medicaid program; and veterans with nonservice-connected conditions who have annual incomes at or below $18,843, if single, and $22,612, if married with one dependent, plus $1,258 for each additional dependent.

The VA is allowed to provide hospital care and nursing home care to other veterans but only if space and resources are available and if they contribute to the cost of care. So called "non-mandatory category" veterans are those with health conditions not related to their military service who have incomes above the mandatory category levels. To receive VA hospital care, they must pay the lesser of the cost of care received or the amount of the Medicare deductible (currently $652) for the first 90 days of care during any 365-day period, plus $10 per day beginning on the first day of care. For each succeeding 90 days of care, they are required to pay the lesser of the cost of care received or half the amount of the Medicare deductible (currently $326) plus the $10-per-day copayment. To receive nursing home care, they must pay the lesser of the cost of care or the Medicare deductible for each 90 days of care during each 365-day period, plus $5 per day beginning on the first day of care. The per-day copayments were first established by P.L. 101-508, and are currently in effect through FY1997. P.L. 101-508 also established $2 copayments for each 30-day supply of medication furnished on an outpatient basis to veterans treated for a nonservice-connected condition (except veterans with service-connected disabilities rated 50% or more), also in effect through FY1997. Legislation adopted at the end of the 102d Congress exempted low income veterans (those eligible for VA pension payments) from the medication copayment requirement (P.L. 102-568).

## Legislation

**Persian Gulf War Veterans.** Proposals to address certain health care concerns related to service in the Persian Gulf War were enacted during the 102d Congress. The Persian Gulf personnel benefits package (P.L. 102-25) included amendments making Persian Gulf War veterans eligible for certain existing veterans' health benefits, for which they would not have been automatically eligible. P.L. 102-25 also expanded eligibility for VA readjustment counseling services under the Vet Centers program to any veteran--including Persian Gulf veterans--who has served on active duty after May 7, 1975 in an armed conflict area. (Vet Centers services formerly were available only to Vietnam-era veterans.) In addition, the law required DOD and VA to submit reports to Congress on the need for services for Persian Gulf service members who experience post-traumatic stress disorder (PTSD), the availability of PTSD treatment services and resources, PTSD treatment plans and related information. A marriage and family counseling program for certain Persian Gulf War veterans and their families was authorized by provisions contained in P.L. 102-405.

Legislation was adopted to require the VA to establish and maintain a registry documenting the health status of veterans who served in the Persian Gulf War theater, including any disability claims filed by such veterans (P.L. 102-585). The measure also required the VA to provide health examinations, upon request, to eligible veterans. The law expanded coverage of the DOD registry (established by P.L. 102-190), which lists service members exposed to fumes of burning oil in the Persian Gulf. In addition, the law required the Office of Technology Assessment to monitor the development and maintenance of both VA and DOD registries, to study the utility of the registries and the adequacy of VA and DOD health examinations, and report its findings to Congress. DOD and VA are required to jointly fund a National Academy of Sciences review of scientific and medical information on the health consequences of in-theater service during the Persian Gulf War. And finally, the law requires the President to designate a Federal agency head to coordinate all Federally-funded research in this area.

**Nurse and Physician Pay.** In response to concerns about the VA's ability to attract and retain qualified health personnel in its hospitals, legislation was enacted to revise the "special pay" rules under which higher salaries are awarded to physicians and dentists for certain recruitment and retention categories specified in law. P.L. 102-40 increased the amounts of special pay that are awarded based on full- and part-time status, length of VA service, scarcity in a medical specialty, and service in executive positions. The law also added "exceptional qualifications" as a new category for which special pay can be awarded. In addition, P.L. 102-40 amended VA labor relations rules to subject certain conditions of medical care employment to collective bargaining rights and to revise grievance procedures for various VA medical care personnel. Legislation was also adopted to amend the nurse pay structure established by the Nurse Pay Act of 1990 to replace the 4-grade structure with 5 grades, revise the methodology used for setting pay levels, require certain nurse pay reports, and make other changes (P.L. 102-585). Other health personnel pay amendments were enacted as part of P.L. 102-405.

**Women Veterans.** Proposals were adopted to expand health services for women veterans, particularly services for women who were victims of sexual abuse during their military service. Provisions contained in P.L. 102-585 authorize the VA to provide counseling to women veterans traumatized as a result of sexual assault (including sexual harassment) that occurred during active duty service. Women veterans are eligible for counseling within two years of discharge from service or, in the case of a veteran discharged before Dec. 31, 1992, not later than Dec. 31, 1993. The VA is required to train health professionals in this area, disseminate information to veterans on the availability of services, and report to Congress on the program. In addition, the VA is authorized to provide certain health services to women veterans, such as pap smears and breast exams; to report on research and services related to health care for women veterans; to appoint coordinators of women's health care in each regional office; and to study the health needs of women veterans.

**Homeless Veterans.** Several proposals to expand VA services to homeless veterans were enacted into law. P.L. 102-405 contains provisions to require the VA to assess homeless programs operated by its hospitals and replicate those considered effective in reintegrating homeless veterans into the community. In addition, VA hospital directors are required to assess the needs of homeless veterans living within each hospital catchment area, determine the extent to which their needs are being met, and, in coordination with other public and private officials, develop a plan to coordinate homeless services among public and private programs. P.L. 102-405 also extended the homeless chronically mentally ill (HCMI) program through FY1994 and authorized $50 million for both the HCMI and the VA domiciliary homeless care programs for FY1993.

In addition, a proposal to demonstrate comprehensive homeless service centers was adopted as part of P.L. 102-590. The measure also required the placement of VA benefits counselors in various VA homeless program sites. In addition, it authorized a new program of grants to nonprofit organizations to conduct outreach and provide training, counseling and transitional housing services to homeless veterans. Grants are for acquiring, expanding, or renovating facilities, rather than for services. Grantees receive per diem payments equal to 50% of the cost for services provided to veterans.

The House Appropriations Committee, in its FY1993 VA appropriations bill report, directs the VA to conduct a study on alternatives for housing homeless veterans in abandoned Federal facilities and to report on progress in meeting the needs of homeless veterans (H.R. 5679, H.Rept. 102-710).

**Post-Traumatic Stress Disorder (PTSD).** P.L. 102-405 contains PTSD provisions, including a requirement that VA develop a plan to expand and improve treatment programs and outreach activities for veterans suffering from PTSD, and report to Congress on the plan within 6 months of enactment.

**Transitional Housing.** Legislation was enacted to authorize a transitional housing demonstration program for veterans in VA compensated work therapy (CWT) programs to assist them make the transition to independent living in the community. P.L. 102-54 authorized the VA to operate up to 50 residences as therapeutic transitional housing. The law also authorized the VA to establish a revolving fund from which funds can be lent to nonprofit organizations for establishing transitional group homes for veterans who are receiving care or received care for substance abuse.

**Resource Sharing.** VA-DOD health resource sharing agreements were expanded by P.L. 102-585 to allow VA and DOD to provide services to CHAMPUS and CHAMPVA beneficiaries. Copayment requirements under both programs can be waived. The VA must consult with veterans' service organizations in carrying out the program.

**Medical Care Cost Recovery.** P.L. 102-568 extended the VA's authority to collect from a service-connected veteran's third party health plan the cost of care provided by the VA for treatment of a non-service connected condition, through July 31, 1994.

**Copayments.** P.L. 102-568 extended the authority for per day inpatient copayments and medication copayments through FY1997 and exempted low income veterans (those eligible for VA pension payments) from the medication copayment requirement.

**Program Extensions and Other Changes.** P.L. 102-86 contains provisions that extended the VA's authority to contract for care for community-based substance abuse treatment programs, through Dec. 31, 1994. The law also extended the VA's authority to contract for care with the Philippines medical center, through Sept. 30, 1992. P.L. 102-585 expanded this authority through FY1996. In addition, P.L. 102-585 contains provisions to authorize a new national preventive health center to carry out research, clinical, and educational activities; require each VA hospital to have a designated indoor smoking area; make the respite care program permanent; and to amend procedures for procuring pharmaceuticals. P.L. 102-585 also made permanent the VA's authority to make grants to State homes caring for veterans.

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## SUMMARY

Americans traditionally have relied on employers for their health insurance. However, in 1991, of the 35.4 million Americans without health insurance, 84% were employed or lived in families of workers. Rising health care costs and changing conditions in the private health insurance market may be leading to a decline in employer-provided coverage.

Employer-provided health insurance has taken center stage in the congressional debate over health care reform. At present, the Federal Government does not require employers to offer or pay for health insurance coverage for their employees or their employees' families. However, as a result of past actions by Congress, employers who offer health insurance have to conform to specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. Mandating that employers provide coverage is viewed by many in Congress as the best way to achieve coverage of uninsured workers and their families. It builds upon the existing employer-based health insurance system, and expands coverage in a way that does not explicitly require significant new spending by the Federal Government.

Many bills introduced in the 102nd Congress would have required employers to provide health insurance to their workers and their dependents or pay a contribution to a public program that would insure uncovered workers and others not connected to the workforce. Additional funds to support the public program would be raised from taxpayers. This approach is referred to as "play or pay." It is a variation of the mandated employer approach in which employers are required to provide and largely pay for a basic health insurance plan for their employees and their employees' families. A smaller number of bills introduced in the 102nd Congress required employers to offer a basic health benefit plan but not to pay for it. President Clinton's campaign plan for national health care reform would phase in a requirement on employers to provide basic insurance.

Substantial controversy surrounds the play or pay approach and employer mandate bills more generally. Proponents argue that providing health insurance is an employer's responsibility. They say that the costs of providing care to uninsured workers are being shifted by health care providers to those employers who provide and pay for health insurance. Those who favor the play or pay approach say that it lessens the costs and administrative burdens of the mandate for smaller employers and other employers that otherwise could not afford to purchase insurance. Opponents argue that it is not an employer's responsibility to provide health insurance, but instead the responsibility of the individual or the Government. They say that many employers, especially smaller ones, cannot afford to offer insurance, even under play or pay approaches. Opponents also argue that the added costs of mandatory coverage (whatever its design) would lead to increased unemployment, especially of low-wage workers, and would reduce their ability to compete with other employers, in this and other countries.

Only one employer-mandate bill, an amended version of S. 1227, had been voted out of committee by the close of the 102nd Congress. But mandated employer coverage is likely to be one of the major health care reform approaches considered by the 103rd Congress.

## Most Recent Developments

In the 102nd Congress, one "pay or play" bill, an amended version of S. 1227 ("HealthAmerica") was voted to be reported out of the Senate Labor and Human Resources Committee. No further movement occurred. However, requiring most employers to provide basic health insurance to their employees was a core part of President Clinton's campaign proposal to provide access to health insurance for all Americans. Assuming that it remains part of the President's reform package sent to the Congress this spring, an employer mandate will be among the leading reform options debated by the 103rd Congress.

## BACKGROUND AND ANALYSIS

### Uninsured Population

In 1978, about 12.3% of the nonaged (below 65 years old) population did not have any health insurance. By 1986, the percentage had risen to 14.8%. The percentage of uninsured held relatively steady through 1990 but jumped to 16% by 1991, possibly due to the increase in unemployment resulting from the recession. In 1991, a total of 35.4 million Americans were uninsured. Low-income households were more likely to lack health insurance than those with middle or high incomes, and 84% of the uninsured are employed or lived in families where the head of the household is employed. (These estimates are based on CRS and Congressional Budget Office analyses of Health Interview Survey and Current Population Survey data.)

The growth in the uninsured over the last decade may have several causes. First, although the proportion of Americans in the work force has been growing, the percent receiving health benefits has been dropping. Some analysts attribute this trend to shifts in employment. Many of the new jobs created in this decade have been in the service and nonmanufacturing industries, the sectors least likely to provide coverage.

Second, the proportion of the population receiving coverage through another family member's employment has been dropping. Several factors have contributed to this decline. As coverage of primary workers has dropped, so too has coverage of their dependents. Also, a growing number of workers appear to be electing coverage for themselves and not their dependents. In 1986, workers who were themselves covered through employment failed to cover their spouses in 3% of the cases. About 8% of the children of insured workers were uninsured. This reflects in part a decline in employer contributions to the cost of dependent coverage, a trend that is continuing. In 1980, 72% of medium- and large-size firms paid the full costs of coverage for their workers, and 51% paid the full cost of dependent coverage. By 1989, fully paid individual coverage was available in only 48% of the firms, and fully paid coverage in 31%. Changes have also occurred in family structure; there are more households with older

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children or unrelated individuals. Such family units are less likely to meet the definitions in insurance coverage rules.

Third, coverage from nonemployment sources declined, particularly Medicaid coverage. In the 1980s, welfare and Medicaid eligibility standards failed to keep pace with inflation; while the absolute number of people in poverty was rising, the number of people receiving Medicaid stayed relatively flat. Recent changes in the Medicaid program, such as initiatives to cover more pregnant women and children, appear to have reversed this trend.

Insurance status has implications for access to health services. The uninsured are less likely to use health services and are more likely to be in poorer health than the insured population. The 1986 National Access Survey (done for the Robert Wood Johnson Foundation) reports, for example, that the uninsured had approximately 40% fewer ambulatory visits and 19% fewer hospitalizations than the insured. Of those individuals surveyed who had chronic illnesses, 20% of the uninsured failed to see a physician or other provider over the course of a year, compared to 17% of the insured. In addition, the uninsured are more likely to delay seeking care; when they seek care, the ailment may be more serious and costly to treat. Also, the uninsured rely more on emergency rooms for basic services, experience higher rates of death in hospitals, and are less likely to receive specific procedures (see, e.g., *Journal of the American Medical Association*, Comparison of Uninsured and Privately Insured Hospital Patients, by Jack Hadley et al., Jan. 16, 1991).

## Working Uninsured

Largely as a result of labor union pressures for better employee benefits, and Federal tax incentives that allow employers to deduct the costs of providing health benefits to their employees, employer-related health insurance became increasingly commonplace after World War II. Today, after paid vacations, it is the most common fringe benefit offered by employers. Sixty-four percent of nonaged Americans are covered by employer-sponsored health plans. As a result (and in contrast to many other western nations where health benefits are provided through government programs), workers in the United States have grown to rely on employer-provided benefits for these basic protections. However, as the following statistics reveal, not all employers offer health benefits and, when offered, not all employees accept them.

A CRS analysis of March 1990 CPS data reveals that in 1989, 17.8 million uninsured workers reported no coverage from an employer plan. Another 10.6 million uninsured were dependents of workers. The majority of uncovered workers are low wage earners. The Employee Benefit Research Institute (EBRI) reports that in 1988, 89% of all uninsured workers earned less than $20,000; 66% earned less than $10,000. Almost 30% of uninsured workers earned less than what was then the Federal minimum wage.

Workers in certain employment sectors are much more likely to lack health insurance coverage than the average American worker under age 65. These include workers in agriculture; retail trade; services (business, repair, entertainment and personal); and construction. Workers in other employment sectors (including manufacturing, finance, transportation, and wholesale trade) lack insurance coverage only one-third to one-half as often as workers in the above employment sectors. The likelihood of being insured under an employer plan also increases with firm size, and being self-employed. According to EBRI, in 1988, close to 50% of uninsured workers were employed or self-employed in firms with fewer than 25 employees.

## History of Federal Employer Mandates

### Requirements on Existing Employer Plans

The Federal Government has traditionally left the regulation of insurance (including rules relating to rating, benefit content, marketing, and solvency) to the States. The Employee Retirement Income Security Act of 1974 (ERISA) -- a Federal law -- preempts States from regulating employee welfare benefit plans. Thus, whereas the States regulate insurers, it is the Federal Government that regulates employers and their health plans. (Hawaii is an exception. ERISA was amended to allow Hawaii to continue its law requiring employers to provide health insurance coverage.) Included under employee welfare benefit plans are self-insured (also known as self-funded) health plans, where the employer assumes all or some of the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk. Accordingly, if an employer purchases insurance, the insurance is regulated by the State. The plan itself is regulated by ERISA. If the employer self insures the plan, it is solely regulated under ERISA. Plans that are regulated under ERISA must comply with notification, disclosure, and fiduciary standards. ERISA does not regulate the benefit content of plans. This means that self-insured employers are relatively free to structure their plans as they desire, of if their employees are represented by a union, through the collective bargaining process. As discussed below, however, both self-insured and insured health employer plans have to comply with specific Federal requirements.

For example, the Health Maintenance Organization Act of 1973 (P.L. 93-222) requires that certain employers with 25 or more employees offer a health maintenance organization (HMO) option in their health plan if a qualified HMO exists in their area. In 1978, Congress amended the Civil Rights Act to extend the prohibition against sex discrimination in employment to include discrimination on the basis of pregnancy, child birth, or related medical conditions (P.L. 95-555). As a result, larger employer health plans must treat women affected by these conditions similarly to other employees, based on their ability or inability to work.

In the 1980s, two other major sets of Federal requirements were imposed on employer health benefit plans: the health insurance continuation requirements under Title X of COBRA and the Medicare secondary payer requirements. In the first case, the passage in April of 1986 of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA), marked a major departure in Federal law and regulation of employers' welfare benefit plans. It was the first time that the Federal Government mandated a specific benefit in employee welfare benefit plans. While COBRA does not mandate that employers provide health insurance, it does require that employers with 20 or more employees who do provide health benefits offer qualified employees and their families the option of continued health insurance for certain periods of time at group rates when faced with loss of their coverage because of certain qualifying events, such as termination or reduction in hours of employment, and death, divorce, and other changes in family status. (See CRS Issue Brief 87182, *Private Health Insurance Continuation Coverage*, by Beth C. Fuchs.)

A different type of employer mandate was legislated through changes in the Medicare program and amendments to the Age Discrimination in Employment Act of 1967. Before 1982, employers generally used Medicare coverage as the basic health insurance for their Medicare-eligible employees supplemented by an employer-provided policy which filled in gaps in the Medicare coverage. This tended to ensure that health care costs for their older workers were confined to supplemental as opposed to basic health care coverage. In 1982, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248), Congress adopted a proposal by the Reagan Administration to require that private employers with 20 or more employees offer their employees and their employees' spouses, age 65-69, their health insurance plan, which would be the primary payer for all claims. The goal was to reduce Medicare expenditures by shifting the health care costs of older workers onto employers. The "working aged" or "secondary payer" requirement was expanded through subsequent laws. The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) expanded the spousal coverage to include all beneficiaries 65-69 with working spouses under age 65. COBRA, (P.L. 99-272) made Medicare benefits secondary to those payable under employer group plans for employed individuals age 65 or over, and the spouses age 65 or older, of any employed individual regardless of age. OBRA of 1986 (P.L. 99-509) included a Reagan Administration proposal requiring employers with 100 employees or more to offer their disabled workers and their spouses the option of coverage under their employers' health plan as the primary insurance policy. OBRA 90 (P.L. 101-508) extended current Medicare secondary payer provisions and lengthens a current law secondary payer requirement relating to end-stage renal disease beneficiaries.

### Move Toward Federally Mandated Health Insurance Coverage

While Title X of COBRA and other Federal requirements affect the nature of employer-sponsored health plans, they do not require employers to provide health insurance to their employees or their employees' families. The idea of requiring employers to provide and largely pay for their employees' health insurance was incorporated in a Nixon Administration proposal for achieving expanding access to health care, called the Comprehensive Health Insurance Plan (CHIP). The Nixon proposal was developed to compete with national health insurance proposals which relied heavily on the public financing and provision of insurance. Neither the employer mandate or public program approach attained sufficient support to be enacted. The Carter Administration also developed legislation to require employers to provide basic health insurance as an employee benefit. Like the Nixon plan, it would have also expanded Federal programs to include those who remain uncovered under employer plans. The Carter proposal was criticized by representatives of small business who argued that requiring them to provide insurance would add significantly to their labor costs and threaten their viability. It also fell victim to an absence of consensus among health policy makers.

Improving access to health insurance reemerged as a major health issue in the 100th Congress. Faced with large Federal budget deficits and an apparent diminished interest in Government-financed solutions, many in Congress turned to employers as a potential source of expanding access to health insurance coverage. In the 100th and 101st Congresses, the Senate Labor and Human Resources Committee marked up and reported favorably to the full Senate bills (S. 1265 and S. 768 respectively) that would have required most employers to provide basic health insurance to their employees and their employees' families. These bills were strongly opposed by small and many large businesses and were never considered by the Senate or the House. Opposition also came from those who favored other approaches to expanding coverage.

In the 102nd Congress, expansion of employer-based insurance through a mandate on employers continued to be favored by many as a way to achieve improved coverage of workers and their families. S. 2114, for example, would require employers to provide basic health care to employees. Employers that fail to provide coverage would be fined $50 a day per eligible employee. However, most proposals (including S. 1177, S. 1227, H.R. 2535, H.R. 3205, and H.R. 5050) adopted a variation of the mandated approach referred to as "play or pay." Under this approach, employers would be required to pay for basic health coverage for workers and their families or to pay a tax (usually based on a percentage of payroll) which, in turn, would be used to provide health insurance benefits to uncovered persons through a public program. Hearings were held on these proposals in both the House and Senate, but only one bill made it through full committee. On Jan. 22, 1992, the Senate Labor and Human Resources Committee voted 10-7 to report an amended version of S. 1227 to the full Senate.

An employer-based approach to expanding coverage is likely to be one of the reform options given serious consideration in the 103rd Congress. This is especially likely since President Clinton has embraced mandated employer provided health insurance as part of his plan to achieve universal coverage. Under the Clinton plan (as developed during the campaign), employers would be phased in under a requirement to provide coverage to their workers and dependents. Subsidies and pooling programs would offset the costs for small firms. Publicly sponsored insurance pools (known as health insurance purchasing cooperatives or HIPCs) would offer a choice of private insurance plans for those persons not covered by employer health plans.

## Issues Related to Mandating Employer-Provided Health Insurance

The debate over mandated employer-provided health insurance raises questions about the potential economic effects of mandates on employers, on employees' wages and salaries, and on the national economy. These questions are especially significant in respect to the effect of mandated coverage on small employers. The debate also raises philosophical issues such as the nature of an employer's obligation to his or her employees, and whether it is appropriate for the Federal Government to require that employers offer insurance.

### Issues for Small Employers

As noted earlier, the likelihood that an employer will offer health benefits increases with firm size. According to a 1989 survey of employers by the Health Insurance Association of America, 26% of firms with fewer than 5 employees offered health benefits. This compares with 54% for firms with 5 to 9 employees, 72% for firms with 10 to 24, 90% for firms with 25 to 49, 97% for firms with 50 to 99, and 99% of firms with 100 or more employees. Of the employed uninsured, 50% worked for firms with fewer than 25 employees.

It is often assumed that smaller employers are less likely to offer health benefits because of the high costs of premiums (generally higher than for large firms), administrative burdens, and the perception that workers prefer cash wages to benefits. Estimates place the costs of insurance for small employers at anywhere from 10% to 40% higher than for large employers.

Researchers have concluded that smaller employers tend not to offer health insurance because they: (1) face higher per-worker premiums since the risk for insurers is spread over fewer persons; (2) do not benefit to the same extent as larger firms from the tax advantages associated with offering health insurance; (3) experience higher fixed costs in choosing and administering a health plan; (4) have relatively higher worker turnover rates and a greater use of part-time and seasonal employees, which increase their administrative fees relative to the fees charged for larger firms; and (5) tend to have narrower profit margins from which to pay relatively higher premiums. The bottom line may be, however, that many small employers do not offer health insurance because they do not need to do so to attract and retain employees.

Associations representing small employers argue that forcing small employers to offer health insurance will result in higher prices, lower wages, more business failures and fewer jobs. They say that a mandate would increase the costs of labor to the point where companies, especially smaller ones, would reduce wages, or in the case of firms with minimum and low-wage workers, reduce their labor force. Health insurance is a relatively expensive benefit. Private sector surveys report that in 1990, health benefits cost on average over $3000 per employee. For the 30% of uninsured workers who are paid less than the minimum wage (based on 1988 EBRI figures), the added hourly cost of a health insurance benefit could be prohibitive, even if the employee were required to pay a share of the premium. Although a mandated insurance package might be less comprehensive and therefore less expensive than the average private sector policy, it could still produce reductions in the employment of low wage workers as employers attempt to adjust to higher labor costs. But it should be noted that there is substantial debate over whether mandated coverage would result in reductions in employment. While some analysts say that a mandate on employers to provide insurance would result in a significant decline in jobs across the economy, others say that any such job losses would be largely offset by the creation of new jobs resulting from the increased demand for health care services.

Another argument used against mandated coverage for small employers is that low-wage workers prefer to receive cash benefits or are already covered indirectly through a family member's insurance policy, and should not be forced to accept reduced earnings. This contention is somewhat supported by surveys of employers.

Many proponents of mandated coverage agree that small employers might be adversely affected if they were required to offer (as well as pay some portion of) health insurance. They suggest, however, that potential problems for small employers could be reduced through mechanisms designed to lower the costs and/or the administrative burdens of offering health insurance. For example, the cost of mandated coverage could be partly or fully offset by tax credits for firms for which the mandate creates a financial hardship. Tax credits, however, are likely to require a significant loss in Federal revenues, especially if health care costs continue to rise at their present rates.

Another possibility for lessening the adverse effects on smaller employers is to allow employers to pay less than would be required if they had to purchase the insurance in the marketplace. This is the rationale for the "play or pay" approach described above. The cost of the mandate to the employer would then depend on the amount of the payroll contribution or tax required by the law. Employers that could buy health insurance for their workers for less than the payroll tax would presumably make that choice. Employers that found the contribution to be less than the cost of insurance would choose to pay. However, any cost, whether it be to play or pay, may be viewed by many employers as too high.

Another possibility would be to encourage the pooling of large numbers of small employers in one large group, thus enabling them to obtain health insurance at lower costs. Pooling mechanisms have been employed with mixed success. (For more on pooling, see *Insuring the Uninsured: Options and Analysis*, by the Health Insurance Team. Congressional Research Service. Washington. 1988.)

## Question of Employer Responsibility

Proponents of mandatory employer-provided health insurance argue that employers have a basic obligation to ensure that their employees have access to health insurance just as they have an obligation to provide a living wage. They assert that a minimum health benefits law should be established in the same manner as the Federal Government has established a minimum wage law. They say that it will ultimately lower the nation's health bill because more people will have timely access to health care. People will seek care when they first need it and not wait until their illness or disability requires heroic and expensive treatment. In addition, they argue that requiring employers to provide coverage is in keeping with the nation's heavy reliance on employment-related insurance. They further assert that relying on private rather than government-provided insurance builds on the American tradition of providing health insurance through a competitive marketplace.

Proponents also argue that this approach will increase equity across employers and taxpayers. According to a CRS analysis (based on March 1990 CPS data), 23 million working Americans receive coverage through employers for whom they are not directly working. In addition, health insurance premiums are priced to include not only the direct cost of providing health care services to an employer's workers, but also other costs borne by the providers of health care for uninsured or underinsured individuals, a substantial portion of which are uninsured workers. Consequently, employers who are paying for health care coverage for their employees are subsidizing those employers who are not paying for coverage as well as subsidizing the costs of care for the nonworking uninsured. On the other hand, individuals who are not offered insurance by their employers are not benefiting from the $46 billion (FY1993) in favorable tax treatment received by employees in firms that provide health benefits. (See CRS Report 90-507, *Taxation of Employer-Provided Health Benefits*, by Beth Fuchs and Mark Merlis. Oct. 2, 1990.)

Opponents of mandatory employer-provided health insurance counter by arguing that employers have no inherent obligation to provide health benefits. They assert that the individual has a responsibility to purchase insurance in the private market. For those individuals who cannot afford to pay for health insurance, then the public sector should provide a minimum level of health care. They argue that an employer's decision to provide insurance or to provide a specific set of health benefits should not be dictated by the Government. Rather, it is labor-management negotiations or free-market competition among insurers vying for employers' business that should determine whether employers provide insurance and if so what health services should be covered under the policy. Health insurance is just one form of compensation and it is up to employers and employees to decide how total compensation will be provided. Such reliance on the marketplace will also ensure greater efficiencies in the supply and demand of health coverage and services, thus helping to hold down costs.

There are also those who reject mandates because they would, in their view, undermine the voluntary nature of employer-provided health insurance. They argue that the majority of employers already provide coverage; it is a benefit that these employers have privately chosen to provide in a form that is most appropriate to their own employees. Some employers who already insure their employees argue that a Federal law mandating that employers provide insurance (particularly if that law were to require a basic minimum level of benefits) would result in higher employee benefit costs and new administrative burdens.

## Mandated Employer-Provided Insurance and Competitiveness

In addition to the debate about employer responsibility, there is a different set of issues relating to the potential effects of mandating benefits on employers' ability to compete in domestic and world markets. Much of the analyses of these effects is speculative; however, the basic arguments tend to be articulated as follows.

Opponents say that mandated insurance would drive up the cost of doing business and reduce the ability of firms to compete, both in the domestic and world markets. Industries that compete against foreign manufacturers (especially those from certain Third World nations) are competing against employers who do not as a rule provide health and other fringe benefits. This helps foreign manufacturers to hold their prices down. Small employers, especially, believe that mandating health insurance coverage might cause them to lose whatever competitive edge they may have since they would have to offset the cost of the new benefits by raising their prices. While many smaller firms do not directly engage in international trade, some proportion of them are suppliers to large companies that do compete internationally. Higher costs for a supplier affect the costs of the purchasing firms: if health insurance coverage were required, small employers might pass the cost of the coverage onto their clients. This reasoning is also extended to domestic competition.

Proponents of mandated coverage dismiss the competitiveness argument as invalid or not compelling. In their eyes, it is not a real issue because the companies that are struggling to maintain their competitive edge (such as the auto manufacturers) are the very companies that already provide health insurance. The majority of the working uninsured are not found in the transportation and manufacturing industries but in the service and retail trade industries, which are comparatively unaffected by foreign competition. It is these latter industries that have experienced the most growth. Mandated coverage proponents conclude that there are more critical variables undermining American competitiveness than the cost to American firms of their employee benefit packages.

Some economists believe both sides are wrong. They argue that employers do not cover their health care costs by raising the price of their products but instead by reducing workers' wages or constraining wage increases. Accordingly, newly mandated coverage would hurt workers' income and not the ability of employers to compete in domestic or world markets.

### "Play or Pay" Option

Similar arguments are made for and against employer mandates that take the form of "play or pay," where the employer would be required to provide health insurance or pay a contribution, usually to a public (Government) program, which would in turn provide coverage to those without employer-provided insurance. Typically, the proposals to establish a play or pay requirement on employers also provide for a taxpayer subsidy of the costs of the public program. This keeps the contribution rate (i.e., the tax on the employer's payroll) for those who choose to pay to a lower level than would otherwise be necessary. Proponents of play or pay say that it would soften the impact of a mandate. Assuming that the contribution rate were set at an appropriate level, employers with low-wage work forces might therefore find it less expensive to pay the contribution than to provide the insurance. In addition, they say that tax credits and other forms of subsidies could be used to lessen the adverse effects of the contribution on employers.

Opponents of "play or pay" say that the economic burden of the contribution on many employers, especially smaller firms, would still be substantial. The contribution rate would be a tax on their business; even if it were less than the cost of buying insurance, it would still drive up the cost of labor. The economic burden of the contribution on many employers, especially smaller firms, would still be substantial. Moreover, they contend that the contribution rate would have to be steadily increased in order to prevent rising numbers of employers from choosing to pay into the public program and dropping their insurance plans. (The logic of this argument is based on an assumption that private insurance should retain a significant role in a universal health insurance program, and that the public program should not become the primary source of coverage for workers and their families.)

## Types of Mandated Coverage Proposals

A variety of approaches to mandating coverage are incorporated in legislation that has been introduced in recent years. While most are aimed at expanding access to basic health insurance by mandating that employers provide health coverage, others seek also to define the nature of the benefits to be offered. As noted above, bills in the 102nd Congress would require employers to provide insurance or pay a percentage of payroll (see, for example, H.R. 1255, H.R. 2535, H.R. 3205, H.R. 5050, S. 1177 and S. 1227). One bill, S. 2114, requires employers to provide basic health care to employees or pay a tax penalty for the period out of compliance. Other proposals would require that employers offer a minimum benefit package but not have to pay for it (see H.R. 1230 and H.R 1565). Some proposals modify Title X of COBRA to extend the duration of continuation coverage for certain populations (see CRS Issue Brief 87182). In past years, proposed bills would have required employers already offering insurance to offer specific benefits, such as well-baby care.

### Defining the Application, Nature and Scope of Mandated Coverage

Should a mandate apply to all employers, and if not, where should the limits be drawn? The Medicare working aged and COBRA Title X provisions exempt employers with fewer than 20 employees, although the OBRA of 1986 Medicare working disabled provisions apply to only those employers with 100 or more employees. Congress has been wary of applying mandates to smaller employers largely because of concerns that they are not as easily absorbed by such firms and could create economic hardships. Congress has also excluded the Federal Government and religious organizations from certain provisions. However, exemptions of small firms or other types of employers could leave many people uninsured, especially if the mandate were not combined with expanded public insurance.

The debate over mandated health insurance coverage is influenced by concerns about the lack of coverage and concerns that working Americans are not adequately protected against the costs of a catastrophic illness. Consequently, there have been proposals in the past to require that employers provide basic hospital and medical insurance as well as those that would mandate only catastrophic illness protection. Another issue is whether the mandate should specify the nature of health benefits to be offered by employers. Again, the proposals vary in their approach. Some, such as 102nd Congress bills H.R. 2525, S. 1177, and S. 1227, would require a minimum level of benefits in the health insurance package. In S. 1227, an actuarial equivalency provision would allow employers to offer different mixes of benefits and employee cost-sharing requirements. Another approach would be to leave the benefit package unspecified or to require that the benefit package total to a specific actuarial value. There have also been narrowly defined proposals that mandate that employers who already provide health insurance include within their benefit package specific services, such as coverage for pediatric preventive health care. (See S. 968 and H.R. 1449, in the 100th Congress.)

### Defining the Population to be Covered and the Duration of Coverage

If a mandated approach were pursued, it would be necessary to define the beneficiaries who would receive the mandated health coverage. The employer's responsibility could be limited to active full-time employees, or expanded to include any or all of the following: part-time, seasonal, or retired employees, spouses, widowed and/or divorced spouses, dependent family members, and employees who have terminated their employment, either voluntarily or involuntarily. Title X of COBRA provides an example of a broad definition of beneficiaries. H.R. 3393 (102nd Congress) illustrates where an employer "pay or play" requirement is limited to coverage for pregnant women and children.

In the same vein, some proposals are directed at ensuring that employers offer health benefits beyond the point at which the employee (and his/her dependents) has an immediate connection with the employer. In the past, Congress has considered proposals to require that employers pay for the continued group coverage of laid-off employees for a defined period of time. In this case, the benefit package may or may not be defined. Such continuation of coverage mandates may extend to laid-off or otherwise terminated employees, retirees of the firm and dependent spouses and dependents of such employees.

### Defining the Liability of Employers and Employees

Mandated coverage bills also generally define the limits of the employer's financial obligation to pay for those benefits. In Title X of COBRA, Congress authorized employers to require the employee to pay for the continued health coverage, plus a small fee to cover the employer's administrative costs. A few 102nd Congress bills (H.R. 1230, H.R. 1565) adopted a mandated offering approach in which employers would be required to offer -- but not contribute to -- a basic package of health benefits. In other proposals, the focus is to keep the employee's costs for coverage low by requiring employers to pay a large portion of the premium. For example, S. 1227 would require that the employer pay 80% of the employee's insurance premium which in turn would be deductible from the employer's taxes as a cost of doing business. The premiums of low-income employees would be subsidized by the public plan. H.R. 2563, in the 101st Congress, would have prohibited employers from reducing their premium shares for certain part-time workers.

Under the various "play or pay" proposals, an employer's financial obligation for providing health benefits would also be determined by the level of the contribution required of those employers who decide not to provide insurance to their employees and their employee's families. "Play or pay" bills in the 102nd Congress generally left the contribution rate to be determined by the Secretary of the Department of Health and Human Services. However, H.R. 2535 provided that if the Secretary does not set the percent, it would be set at 7% of payroll. H.R. 3205 set the initial payroll tax at 9% of the Medicare wage base and then indexed it for inflation.

## Legislation in the 102nd Congress

The HealthAmerica bill (S. 1227) was introduced by Senator Mitchell June 5, 1991, titled HealthAmerica: Affordable Health Care for All Americans Act. The bill would have amended the PHS Act, the SSA, and the IRC to require that 6 years after enactment, almost all employers would provide qualified health benefits to their employees and their employees' families or contribute to a public program (AmeriCare) a percent of payroll. The "play or pay" requirement would have been phased-in, with the requirement affecting employers with over 100 employees in the second full year after enactment. Employers that provide health benefits would have to pay 80% of the premium (the premiums of low-income employees' could be subsidized by AmeriCare). The bill provided for minimum standards to make insurance sold to smaller firms more accessible and included cost containment and other provisions. It was referred to the Committee on Finance. Hearings were held Sept. 30, 1991 by Finance Subcommittee on Health for Families. An amended version was voted to be reported by the Senate Labor and Human Resources Committee on Jan. 22, 1992.

## LEGISLATION

**H.R. 30 (Grandy)**
Health Care Empowerment and Access Legislation. Amends ERISA, the Internal Revenue Code (IRC), the Public Health Service (PHS) Act and the Social Security Act. Requires employers to offer coverage for eligible individuals under basic group or group health payroll deduction plans. Introduced Jan. 5, 1993; referred to Committees on Education and Labor, on Ways and Means, and on Energy and Commerce.

# Health Care Reform: Single-Payer Approaches

## SUMMARY

Among the more than 100 health care reform bills introduced in the 102nd Congress were many proposals to provide health insurance to most or all Americans through a "single-payer" system. Such bills were backed by many Democrats and some Republicans, who claim that affordable health care for all is best achieved by ending the complexity and inefficiency resulting from our current system of multiple insurers, private and public, each with their own eligibility requirements, benefit packages, provider payment rules, and administrative expense. Single-payer bills will be competing with other reform approaches in the 103rd Congress (managed competition, tax approaches, etc.), each potentially producing different distributional effects on access and cost.

Proposals bearing the label "single payer" take a variety of forms. Most commonly, the term is used to describe a system in which the government would sponsor and pay for health care for all; often, such single-payer plans rely on broad-based taxes. Payments to providers are regulated and flow through a single pipeline; system-wide limits on spending may be imposed. Existing public insurance programs are subsumed under the new program; private insurance is eliminated or operated only to cover services not insured under the government plan. The system would be implemented at the national or State level, or through a Federal-State partnership. In the parlance of today's debate, it is the "Canadian approach." Other proposals use "single payer" to describe a system in which a framework is established for one Federal or State payer but other insuring entities (such as HMOs) are available as alternatives, assuming they play by certain rules. Additional single-payer variants are found as well.

Single-payer approaches are supported by some consumer and physician groups and some employers and unions. Proponents say that moving to a single-payer, public insurance program covering all Americans would save billions of dollars in administrative expenses. In addition, they say it would end the shifting of costs from one insuring entity to another that currently impedes efforts to control spending. Assuming government subsidies of lower-income populations, such a system also would ensure universal access to adequate and affordable health insurance, without regard to ability to pay. Opponents argue that a single-payer system would lead to bureaucratic medicine in which consumer preferences would give way to government preferences in the determination of who gets what health care. They say it would reduce the innovation and diversity that has helped to bring the U.S. advances in health care delivery, technology, and financing. Opponents also claim critical medical resources would end up being rationed; millions would see their health insurance coverage deteriorate.

Major issues arising with respect to single-payer proposals include: the potential system-wide savings in administrative expenses (estimates greatly vary); the adequacy of the benefit package; methods for containing physician, hospital, and other provider costs (proposals differ in the stringency of cost controls); methods of containing system-wide expenditures; and ways to finance the system to achieve the preferred distribution of program costs among consumers, employers, and governments.

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## Most Recent Developments

**On March 3, 1993, Rep. McDermott and Senator Wellstone introduced the American Health Security Act of 1993 (H.R. 1200 and S. 491), a revised version of Rep. Russo's 102nd Congress single-payer proposal. The McDermott-Wellstone proposal is seen by many as the major alternative to employer-based and tax-system options for expanding financial access to coverage. It is also viewed as an alternative to managed competition for achieving containment of health care costs. Single-payer proposals will be among those debated by the 103rd Congress as it considers ways to achieve health care reform.**

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## BACKGROUND AND ANALYSIS

More discussion of health care reform is occurring today than at any time since the 1970s. This interest has been fueled by health care spending projected to reach almost 19% of the national economy by 2000 and rising numbers of uninsured (over 35 million in 1991). The public's concerns about unpaid medical bills, being locked in a job to maintain health benefits, and escalating insurance premiums have brought renewed attention to issues of universal coverage and cost containment. Over 100 reform proposals were introduced in the 102nd Congress, and health care reform was a major issue in the 1992 Presidential campaign. President Clinton has said that he will send a comprehensive reform proposal to Congress later this spring.

One reform approach favored by some Members of Congress calls for moving away from our existing system of multiple sources of insurance to a system in which one entity serves as the insurer of all Americans. This is often called the *single-payer* approach. Single-payer bills in the 103rd Congress include, for example, H.R. 16, H.R. 1200 and S. 491. In the 102nd Congress, there were also bills to expand Medicare to cover everyone, a clear variant of the single-payer approach (H.R. 650, H.R. 1777). Another set of bills would have established State administered universal insurance programs, relying primarily on a single public payer. These included such bills as H.R. 16, H.R. 3689, H.R. 5500, S. 1446, S. 2513, and S. 3331. Some of these bills would have encouraged managed care plans, such as health maintenance organizations (HMOs), as an alternative to the single public plan. Such single-payer proposals will be among the options considered by the 103rd Congress as it debates health care reform. Other options, however, including an employer mandate combined with managed competition, appear to be gaining more support both in Congress and within the Clinton Administration. (See **FOR ADDITIONAL READING** for CRS products covering other approaches.)

### What is the Single-Payer Approach?

Americans receive health insurance today from a wide variety of sources, including over 1200 commercial insurers, about 550 health maintenance organizations (HMOs), 73 Blue Cross/Blue Shield plans, self-insured plans operated by private employers, local and State governments, the Federal-State program for the poor and disabled (Medicaid) and the Federal Government (including Medicare, and the Veterans' Administration and Defense Department programs). Each insuring entity has its own eligibility requirements, enrollment procedures, claims processing, and utilization and quality review programs, all of which add to administrative expense. For this reason, many people describe our system as multipayer or pluralistic.

Opponents of the current multipayer system say that the hundreds of different public and private insuring entities needlessly complicate the system and drive up the cost of health care. In their view, reform requires that we streamline the system, that we move towards a few entities, or a *single payer*, through which health insurance would be financed and medical services reimbursed. Such a system, they argue, would effectively contain costs because the single payer would exert monopsony power over provider payments. If a provider did not like what it was getting, it could not turn to another payer in the hopes of getting more, as it can in a multipayer system. It would also eliminate duplicate administrative costs.

Proposals bearing the label "single payer" take a variety of forms, and as such, the term can be more confusing than helpful as a tool of classification. Most commonly, the term "single payer" is used to describe an approach in which the government sponsors and pays for health care for all persons. Everyone gets their basic health insurance from the one government sponsored (i.e., public) plan. Typically, such single-payer plans are financed with revenues generated from income, payroll, and other taxes. All payments to hospitals, physicians, and other providers are regulated and originate with the government plan. System-wide controls on spending may also be in place. Existing public insurance programs, including Medicare, Medicaid, and Department of Defense and Veterans' Affairs programs are subsumed under the new, government program. Private insurance is either eliminated or maintained only to cover services not insured under the government plan. Such a single-payer approach can be implemented at the national or State level, or through a Federal-State partnership. In the parlance of today's debate, it is the "Canadian approach." It is most clearly reflected in such 103rd Congress bills as H.R. 1200 and S. 491 and such 102nd Congress bills as H.R. 650 (Stark), H.R. 1300 (Russo), H.R. 2530 (Sanders), and S. 2320 (Wellstone).

Some proposals use the term "single payer" even though more than one entity may be authorized to play that role. These proposals set up a framework for one Federal or State payer but permit other insuring entities, such as HMOs or large employers, also to act as insurers, so long as they can meet specific requirements. While providers may receive payment from several sources, the rates of payment are typically set by the public insurer. At some point, such "single-payer" proposals begin to look more like the "all payer approach" reflected by the German health care system, and some State "all payer" rate regulation systems in which insurance companies and employer health plans are required to pay providers using predetermined uniform rates and fees, usually set through negotiation with providers. (Examples in the 102nd Congress include H.R. 3205 (Rostenkowski), H.R. 5502 (Stark), and H.R. 4889 (Cardin)). There are also proposals that channel the revenues for health insurance through a single entity, such as the Federal or a State government, but provide insurance through multiple public and public entities. The Dingell-Waxman bill in the 102nd Congress (H.R. 5514) took this approach, as does the plan proposed by California's insurance commissioner, John Garamendi.

This issue brief focuses on single-payer proposals that provide insurance coverage for all under one public program, which in turn is the main source of payment to physicians, hospitals, and other providers. It includes plans that are organized at the national as well as State level. It also includes plans that establish the structure for a single-payer system but permit qualified health insurance arrangements, such as HMOs, to provide health insurance as well. While single-payer proposals could provide for public ownership of health care facilities and making all physicians and other providers employees of the public plan, this is not a requirement. Indeed, all but one bill in the 102nd Congress (H.R. 3229), would have maintained a private delivery system.

## Interest Group Views

Among interest groups, universal, single-payer public insurance is supported by some consumer organizations (Citizen Action, Consumers Union, Public Citizen), some provider organizations (Physicians for a National Health Program, National Association of Social Workers), and some unions, including the American Federation of State, County and Municipal Employees. The AFL-CIO has been split, with some members favoring comprehensive reform through the single-payer approach, and others supporting an employer-based, play-or-pay option. While some representatives of large corporations have expressed private support for the single-payer approach, organized corporate and small business interests (Chamber of Commerce, ERISA Industry Committee, National Association of Manufacturers, and National Federation of Independent Businesses) are opposed. Also opposed are most provider groups, including the American Hospital Association, the Federation of American Health Care Systems, the Pharmaceutical Manufacturers Association, the American Medical Association, as well as organizations representing the insurance industry, including Blue Cross and Blue Shield and the Health Insurance Association of America.

## Arguments For and Against the Single-Payer Approach

Proponents of a single-payer approach use one or more of the following arguments to support their position:

*Curb cost-shifting.* Current cost containment efforts have not been effective because health care is financed and delivered through a nonsystem of multiple entities, each acting on its own behalf to shift the burdens of controlling costs and ensuring access to someone else. If cost constraints are placed on any one entity, such as Medicare, providers seek higher reimbursement from other payers, such as private insurers and employers. Under a pure single-payer system, one entity would be vested with the authority to determine how much money would flow to providers and to set rates and fees paid to providers within that overall limit. Providers could not seek additional payments elsewhere because there would be nowhere else to go. (Some proposals might allow providers to bill patients directly, but many prohibit such balance billing to protect enrollees from potential cost shifts.)

*Streamline administration.* Under our current system, billions of dollars are spent on administration, that is, on transactions between payers, providers, and consumers that have nothing to do with the actual delivery of medical services. Duplication and overlap result from the information requirements of multiple organizations; excessive red tape results from different eligibility and coverage rules. Such costs would be substantially reduced under a single-payer system. One entity would be enrolling beneficiaries and paying claims. The administrative costs associated with private insurance, such as marketing, risk selection (underwriting), and the payment of agent commissions, would be eliminated. Other costly administrative transactions, such as data collection for quality assurance and utilization review, could be streamlined and improved. With only one payer instead of hundreds, physicians, and other providers would be subject to more uniform standards of medical review, reducing the intrusion on their clinical decisions. In short, the single-payer approach provides for simplicity of structure and organization that no other approach under discussion can match. Employer-based options, for example, require complex arrangements to ensure that everyone retains insurance, regardless of work status. (The issue of administrative costs is discussed in more detail below.)

*Ensure universal access and continuity of coverage.* Today, reliance on employer-based insurance for the majority of Americans leads to gaps in coverage for millions of workers and their families. In addition to the millions of uninsured whose employers do not offer insurance are millions more who experience temporary losses of coverage as they move in and out of jobs or on and off medicaid. A single-payer system would eliminate the reliance on employment as the principal path to becoming insured. All Americans would be covered under a single insurance program, without regard to health status, medical history, linkage to employment, or -- at least in most bills -- ability to pay. This would also ensure continuity of insurance coverage because changes in job or family status would not cause interruptions in payment for ongoing services.

*Provide uniform benefits.* Under the current multipayer system, benefit coverage varies widely. For example, persons covered under large employer group plans typically receive comprehensive benefits, and pay low deductibles and coinsurance. Persons covered under nongroup (i.e., individual) policies typically receive less generous coverage, and pay high deductibles and coinsurance. A single-payer system would ensure that everyone would be eligible for the same set of basic benefits, provided under the same set of cost-sharing and reimbursement rules. The source of insurance would no longer be a cause of inequality in access to care.

*End rationing on the basis of ability to pay.* Opponents of the single-payer approach argue that it will lead to rationing of medical resources, including high technology equipment, thereby reducing access and quality of care. Single-payer proponents respond that health care is already rationed in the U.S. by ability to pay; those who are uninsured get less care and poorer quality services than those who have insurance. Under a single-payer program, rationing would be explicit, subject to public debate, and independent of a person's financial status. Also, the U.S. currently has substantial excess capacity of hospital beds, physicians (particularly specialists), technology, and unnecessary services. By managing provider payments and the distribution of technology, the single-payer system could achieve universal access and cost containment without having to ration services.

Opponents differ in their arguments against a single-payer approach depending on their perspective. Some believe that a single-payer plan is desirable but not politically feasible; others prefer an alternative approach that builds on our existing system of public and private payers, such as mandated employer-provided insurance. Still others prefer to leave the broad sweep of decisions relating to insurance entirely to the private market. In any case, opponents often suggest single-payer plans would:

*Bureaucratize health care.* Market competition encourages insurers to be responsive to consumer needs and to provide services as efficiently as possible. Consumers can elect a health plan that best meets their individual needs. A single-payer approach, such as one fashioned after the Canadian system, calls for one large public program controlled and administered by government, be it Federal or State. Decisions traditionally left to the market would become centralized and bureaucratic. Consumer preferences would give way to government preferences. Key decisions about benefits and the use of scarce resources would be determined by politicians. Such an approach stands in striking contrast with Americans' traditional distrust of government. The public would not accept one government entity making all coverage and payment decisions for 250 million enrollees in a fair, efficient, and accountable manner. Moreover, the administrative costs associated with the current multipayer system could be substantially reduced without adopting the drastic change required by a single-payer model. Reducing unnecessary paperwork and red tape, streamlining review and billing procedures, and reforming health insurance rating and underwriting practices could significantly reduce administrative costs without abandoning our multipayer system.

*Reduce innovation and diversity.* The advantage of the existing system of many payers is that competitive pressures stimulate payers to seek new solutions to access, cost, and quality problems. Employers and employees demand from insurers that coverage be comprehensive and allow access to high quality of care. Under a single-payer system, much of this innovation would be lost. In addition, a single-payer system assumes that "one size fits alls," when instead, one size or, in this case, payer, may stifle innovation, concentrate too much power in one place, and become administratively rigid.

*Encourage rationing of medical care.* To contain costs, single-payer systems such as the Canadian system have had to resort to blunt and potentially harsh constraints on medical resource supply, including constraints on overall expenditures, limits on the availability of high technology equipment and services, and limits on physician supply. Such steps are likely to lead to shortages of technology and personnel, and delays in the replacement of out-dated hospitals and other facilities. This could mean a sacrifice in access to necessary services, long waits for nonemergency services, and reductions in quality of care.

*Reduce benefit coverage and jobs.* Movement to a single-payer system would result in enormous dislocations of people. First, millions of Americans who are currently satisfied with their health insurance plans would be moved to the new program. For some, the move would result in the loss of benefits they consider important (extended mental health care or comprehensive dental coverage, for example). Second, while some of the thousands of employees of private insurers might be absorbed by the new single-payer plan, many could face unemployment. Many insurance companies would go out of business; independent insurance agents would lose a major source of their income.

## Administrative Cost Debate

As noted above, a principal and controversial argument in favor of moving the U.S. to a single-payer system is that the amount of money spent on administration would be reduced. Data from other countries, especially Canada, are often used to support this claim.

Administrative costs are generally defined to include: (1) public and private insurance overhead (processing claims, advertising, underwriting, billing, general operating overhead, agent commissions, premium taxes paid to States, profit, and any amounts held in reserve to cover unanticipated losses); (2) provider overhead, including that of hospitals, nursing homes and physicians (accounting, billing and collection, admitting, public relations, personnel department, data processing, etc); and (3) all other, including the administrative costs associated with running small government programs, manufacturer/supplier compliance costs, the administrative costs of research, construction, and other public health activities; the costs to employers of administering health plans; and the administrative costs of nonhealth insurance, such as auto insurance, which pays for medical care.

A true accounting of these costs is problematic given the limits of current reporting systems. For instance, reliable national level data on hospital or physician administrative costs are unavailable. Also, it is difficult to sort out those provider costs which are associated with dealing with health insurers from those that are purely necessary for patient care. The only routinely published national administrative data are those associated with the administration of private health insurance, $47 billion in 1992 (5.8% of the Nation's spending on health care), and the Federal costs of administering Medicare and Medicaid, $8 billion in 1992 (less than 1% of total health spending). (These are Congressional Budget Office -- CBO -- estimates, based on Health Care Financing Administration data.) The expenses incurred by doctors and other providers as a result of multiple claims and billing forms and the personnel to take care of them are not reflected in these estimates.

In comparing administrative costs across health systems, such as the United States with Canada, the task is more complicated. Data comparability is one problem. For example, physician overhead expenses may be reported differently in different countries. Also, analysts differ on how much to assume can be saved by transferring one nation's system to another. If the United States adopts the Canadian model, should it be assumed that it is also adopting its expenditure controls, such as hospital global budgets? And, what costs should be included in the estimate? Danzon (*Health Affairs*, Spring 1992) has argued that comparing administrative costs of alternative systems by adding up billing costs, insurance overhead, and the like is misleading because it fails to include the hidden costs and benefits associated with financing and operating different systems. In her view, a system based on multiple private insurance plans may cost more because such plans facilitate varying consumer preferences with respect to providers and delivery systems, benefit packages, and cost-sharing. On the other hand, she says, a Canadian-like system wastes valuable patient and provider resources (such as time) by requiring people to wait for nonemergency services. Also, the Canadian system's reliance on tax based financing encourages losses in productivity and investment as individuals seek to avoid taxed activities. Others dispute Danzon, saying she ignores the actual experience of Canada and other single-payer systems in favor of an ideological preference for a private insurance market.

Given these controversies, it is not surprising that a wide range of estimates have been produced on how much the U.S. could save by moving to a single-payer system like that of Canada. Woolhandler and Himmelstein have concluded that the U.S. would have saved as much as $83 billion had its health care administration been as efficient as that in Canada in 1987. Adjusted for 1991, the amount would have been $95 billion. The General Accounting Office (GAO) has estimated that a Canadian-style system would have saved the U.S. $67 billion in 1991. A lower set of estimates include that of Lewin-ICF ($47 billion), a minority staff report of the Joint Economic Committee ($43 billion); a CBO staff study ($41 billion); and an Office of Management and Budget staff estimate of $31 to $49 billion. (Some of these studies are summarized in Gauthier et al., *Inquiry*, Fall 1992.)

Whatever the magnitude of the savings, most analysts agree that movement to a universal, single-payer system would not eliminate all administrative costs. It would reduce the direct and indirect costs associated with insurance, such as those associated with eligibility determinations, marketing, and processing the large assortment of claims and billing forms. It would not eliminate the need for maintaining patient records, complying with government regulations, and other administrative tasks that play a role in and add to the costs of health care delivery.

## Major Issues Relating to Single-Payer Proposals

The debate with respect to single-payer approaches to health system reform raises questions about access, benefit coverage, and quality; cost containment; and financing. The wide variation in treatment of these issues in the various proposals reflects different objectives and philosophies and would produce substantially different distributional effects.

### Access, Benefit Coverage, and Quality

Single-payer proposals generally provide access to insurance coverage to all legal residents. Some bills phase in access, typically starting with children and sometimes early (pre-Medicare) retirees. Others provide for a one-time move to universal access. Effective dates for coverage of specific populations are generally linked to financing. As the pool of available revenues grows (either through taxation or savings from cost containment measures), new populations are made eligible for coverage under the program.

Single-payer proposals usually provide for coverage of comprehensive acute care services, including inpatient and outpatient hospital care, physician, laboratory and x-ray services, and post hospital care. To this extent, single-payer and "Medicare-for-all" bills are similar. They tend to diverge with the increasing generosity of the benefit package and declining reliance on enrollee cost sharing. Some single-payer bills also include prescription drugs, and/or long-term care services. Some provide all covered services free to the patient at the time of service, while others require enrollees to share in the cost of the insurance (see **Financing**, below).

Another benefit design issue is whether a proposal allows consumers to buy private insurance duplicating the benefits of the public insurance program. Some believe that such a provision would encourage two-tier health care because those with an ability to pay would opt for private insurance. Accordingly, some proposals explicitly prohibit private insurers from selling coverage duplicating public program benefits. A related issue is whether physicians and other providers can receive payment for services from other than the single-payer entity. Under the Canadian system, for example, physicians must decide whether or not they want to participate in the provincial health plan. They cannot accept payment from private insurers if they receive provincial plan reimbursement. Those few that do not participate in the provincial plans tend to be in specialties providing services not covered by the plans (e.g., cosmetic plastic surgery). In England, specialists that are salaried under the National Health Service (NHS) are permitted also to take patients on a fee-for-service basis. As a result, patients with the ability to pay (or who are privately insured) sometimes pay privately for elective procedures rather than wait for them under the NHS. Critics claim that this leads to inequitable access to nonemergency care.

Most proposals do allow private insurers to sell policies that supplement the benefits provided under the public program. This would enable consumers to purchase policies, for instance, that cover so-called amenities, such as private hospital rooms, as well as services that exceed public program limits (e.g. extended treatment for mental illness) or are not covered by the public program. The effects of supplemental coverage on total system spending and equity then have to be considered.

Quality assurance under the single-payer proposals is inherently linked to the method of paying providers (see **Cost Containment**, below). But most proposals also include mechanisms aimed at regulating the quality of services provided to program enrollees. Several 102nd Congress bills incorporated Medicare quality assurance standards and procedures. Some bills would have increased Federal funding for outcomes research and the development of clinical practice guidelines to make medical services more appropriate and effective. Some charged the States with implementing quality assurance measures.

## Cost Containment

In addition to savings on administration achieved by eliminating multiple payers, single-payer proposals generally include other measures aimed at controlling costs. These include: constraints on medical resource supply (e.g., planning and regulation of the distribution of high cost technology, expanded Federal technology assessment, and/or increased Federal funds for outcomes research and clinical practice guideline development); and incentives to encourage more primary care. Potentially most important to cost containment, however, is the manner in which the proposals seek to regulate payments to providers and/or control system-wide health expenditures.

**Regulating provider payments.** Most single-payer proposals include controls on the rates (prices) charged by providers. These take a variety of forms. Some proposals call for the use of Medicare's prospective payment system for hospitals and its resource-based relative value scale (RBRVS) method of setting fees for physicians. Others call for the use of negotiation processes to set hospital and physician payment rates. Still others would leave decisions on rate setting to an independent board or to the States. If the bill allows HMOs to operate as an alternative to the public program, capitation payments are permitted. (Capitation is a method of paying for an individual's medical care through a per capita payment that is independent of the number of services received or the costs incurred by providers in furnishing those services. Capitation rates are typically set in advance of payment.)

While rate regulation may help control prices paid to providers, it could encourage providers to offset price limits by providing an increased quantity and intensity of services. If a physician, for instance, cannot charge more than $100 for a procedure, then he or she may be encouraged to provide more of that procedure or substitute procedures for which the unit fee is higher in order to maintain his/her expected income. In response, some proposals would establish an expenditure target for all physicians in a State (or other geographical area). If physicians in the aggregate were to exceed the ceiling, then all physicians would be penalized by receiving a lower than scheduled annual update in their fees.

Some analysts believe that expenditure limits designed in this fashion would not be very effective in controlling the growth in volume and intensity of services because individual physicians would not see their individual actions directly influencing future fee schedule adjustments. They believe potentially more effective alternative would be to place an expenditure target or limit on smaller subsets of physicians, such as all physicians in an area, specialty, or group practice. More effective still might be limits on the fees of individual physicians. In this case, once a physician reached his or her preset expenditure limit, reimbursement for additional services provided during the remainder of the payment period would be substantially reduced. One concern with this approach is that it could reduce patient access if physicians responded to reaching their expenditure cap by going on vacation or refusing to accept patients requiring a lot of time and/or resources.

A related cost containment measure is often referred to as global budgeting, and is usually applied to hospitals or other large providers of services. Global budgets define the total resources available for treating all patients and place the responsibility for cost containment on the actual providers of care. Accordingly, each hospital, nursing home, clinic, etc. is placed in a position of operating within predetermined limits which affects its decisions regarding treatment and resource allocations.

**System-wide (global) expenditure limits.** The most expansive cost controls are those that establish targets or limits on total system-wide health care spending. Under this system-wide target or limit, spending is then limited within each health care sector (usually within each State or geographic region) to an annual amount. Spending in excess of the limit is penalized by offsetting adjustments in subsequent periods. Important issues then arise with respect to determining how to define and allocate spending within each sector and determining allowable rates of growth. Should, for example, all physician services be bundled together or separated in some way? Should the expenditure limit take into account general inflation, demographic changes, and changes in medical practice and technology, or should it be linked to overall economic measures, such as the growth in wages or the growth in the economy?

Proponents of system-wide expenditure limits say that limits would help discipline spending and facilitate predictability and planning in public and private budgeting for health care. Resource allocation decisions would necessarily become explicit political questions, which would encourage the Nation to debate priorities and assess tradeoffs. Opponents say that expenditure limits could lock in existing inefficiencies in the system. Besides, they say, we do not have the data to determine how to allocate spending limits. They also argue that it is unrealistic to expect the limits to be enforced, especially if such decisions lead to rationing of services. Some opponents also oppose expenditure limits because they would, in their view, replace marketplace decisions with government controls.

## Financing

**Sources of Financing.** Under the current mixture of public and private financing, individuals, governments, and employers share in the burden. Individuals directly finance health care costs through premium contributions and out-of-pocket payments. The insured generally contribute all or a share of the premiums and pay out-of-pocket for deductibles, coinsurance, and uncovered services. The uninsured may bear significant out-of-pocket costs for received services.

Federal, State and local governments today contribute a major share of the total dollars spent on health care. The burden of government financing is distributed among taxpayers through a mixture of tax levies, including individual and corporate income taxes, the Medicare payroll tax, excise taxes, and at the State level, property, income, sales and excise taxes. Government also indirectly helps to finance (and thus encourage) employer-provided health insurance through various tax expenditure provisions of the Internal Revenue Code.

Businesses account for the remaining share of total health care expenditures. Much of that cost is incurred providing health benefits for employees and their families, and paying the employer share of the Medicare payroll tax and other payroll taxes that support the medical portion of State-mandated workers' compensation and temporary disability insurance programs. Some economists assert that employer contributions are really costs to employees since they are likely to reflect foregone wages. From this perspective, it could be said that individuals ultimately finance all of health care in the form of taxes, reductions in wages, increases in prices, and out-of-pocket payments.

Proponents of single-payer plans generally believe that we need to move away from what they say is a complex, sometimes hidden, and often regressive way of financing health care to a system that is largely financed on broad-based and progressive taxation that is decided in the open political arena. Opponents tend to argue that such a system would lead to highly politicized decision making about how much money to raise and how the money should be spent. They say that politicians would be unwilling to risk voter anger to fully finance the system and scarcity of health care resources would result.

**Financing the Single-Payer Program.** Any single-payer initiative will draw on revenues from individuals, government, and/or business, and in so doing, is likely to alter the current distribution of the financing responsibility. Most single-payer proposals are explicitly designed to spread the responsibility of providing universal coverage broadly among taxpayers by providing for government financing. Such proposals generally rely on broad-based taxes, such as personal and corporate income taxes, as well as payroll taxes, with some financing responsibility left to enrollees through premiums and coinsurance. A consumption tax, such as a value added tax (VAT), is also sometimes accorded a role in such proposals. Some proposals raise part of the revenues through excise taxes on alcohol and tobacco products. Still another source of revenues may be State contributions, often set at an amount approximating the State's Medicaid payments for acute care services.

The income tax is generally viewed as the most progressive revenue source because it is designed on the basis of ability to pay. Financing health care through a progressively structured income tax is assumed by many to be the most equitable way to spread the cost of health care across the entire population; most single-payer bills therefore rely to some extent on increases in Federal income taxes (usually by raising rates on higher-income taxpayers). Others believe that higher users of health care should have to pay more, especially those with high risk behaviors, such as smokers and drinkers. Opponents of an income tax-supported system argue it would lose out in competition with other government programs for needed funding, especially if the revenues were not dedicated to a health insurance trust fund. In another vein, some say that financing health insurance through increases in Federal income taxes is politically unfeasible because of general voter opposition to tax increases. Proponents respond that voters would accept tax increases to finance a universal health insurance program if they were persuaded that other financing options were less desirable.

Payroll taxes also are used to finance many of the single-payer proposals. Such taxes are typically levied at a flat rate on wage income, usually up to some dollar ceiling, and are thought to be more regressive for workers because wage income is a smaller fraction of total income at higher income levels. Payroll taxes may also penalize labor intensive industries in favor of capital intensive ones. A variety of measures can be used to reduce the regressivity of payroll taxes, such as basing a portion of the employer contribution on profits instead of payroll. Consumption taxes are usually considered to be neutral with respect to labor or capital intensity of firms. Because they are levied at a flat rate and because lower-income people use more of their income for consumption than savings, they are regarded by many as regressive. They can be made less regressive depending on which items are exempted from the tax and whether other tax mechanisms are used to offset their effects on income.

Direct consumer financing in the form of enrollee premiums and/or cost sharing also is used in most of the single-payer proposals. Premiums tend to be scaled to income to limit their potential regressivity. Some bills use premiums to finance specific benefits, such as long-term care. Cost-sharing is included in some bills but is generally waived for certain services, such as prenatal and well-baby care. Proponents of consumer cost-sharing say that it is important to sensitize consumers to the cost of services and to discourage unnecessary utilization. Opponents say that it mostly discourages low-income enrollees from seeking services but has little effect on those of greater means, that it may deter necessary as well as unnecessary care, and that it does little to alter the course of care once treatment has begun because the decision-making has shifted to the physician.

## LEGISLATION

### H.R. 16 (Dingell)

National Health Insurance Act. Provides health insurance coverage for most U.S. residents; replaces all insurance except Medicare. States and localities would administer plans with Federal assistance. Introduced Jan. 5, 1993; referred to Committees on Energy and Commerce and Ways and Means.

**H.R. 1200 (McDermott)**

American Health Security Act. Establishes a universal health insurance program to replace all other private and public coverage. State administered, single-payer system. Global budgets would be established for hospitals; physicians would be paid negotiated fees; other services also would be subject to cost controls. The nationally, the growth in expenditures would be limited to the growth in the cost of living. Financing would come from funds currently received by Medicare (other than premiums), Medicaid, and other specified Federal health programs; increases in corporate and individual income tax rates; a new Health Security premium; a surtax on individuals with incomes over $1 million; payroll taxes; and from funds generated from a variety of other tax changes. Introduced Mar. 3, 1993; referred to Committees on Ways and Means, Energy and Commerce, Armed Services, Post Office and Civil Service, and Veterans' Affairs.

**S. 491 (Wellstone)**

American Health Security Act. See H.R. 1200. Introduced Mar. 3, 1992; referred to Committee on Finance.

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## SUMMARY

Bills providing for changes in Federal tax law to promote financial access to insurance coverage and medical services or to contain health care costs are likely to be among those receiving serious consideration by the 103rd Congress as it begins its work on health care reform. Many such bills were introduced in the 102nd Congress and a program of tax credits and deductions was the cornerstone of President Bush's health care reform plan. Tax-based measures were part of President Clinton's campaign proposal for health care reform and may be included in the health care reform proposal he sends to Congress later this year.

Under current law, the Federal Government provides incentives to employers to furnish health insurance by treating the cost of insurance as a deductible business expense and by excluding employer-provided benefits from taxable employee income. In addition, individuals may deduct medical expenses, including health insurance premiums, to the extent to which those expenses exceed 7.5% of adjusted gross income. Low-income families may also receive a tax credit for part of the costs of purchasing coverage for children. In 1993, the reduction in Federal revenues resulting from the individual medical expense deduction and the exclusion of employer-provided benefits from employees' taxable income will total close to $50 billion.

Proposals to modify the current tax treatment of health insurance have arisen in the context of the broader debate over how to provide health coverage to the uninsured (35.4 million in 1991) while controlling the growth in national health spending, projected to reach $808 billion, or 13.6% of gross domestic product, in 1992. Tax system changes may serve either of these two broad objectives. On the one hand, enhancement of existing deductions and credits could encourage individuals to purchase coverage or employers to provide it to their workers. On the other hand, limits on the favorable tax treatment already provided for health coverage could encourage restraint in personal health spending. While the two goals appear to be in conflict, many proposals embody both approaches, using savings from limiting tax benefits for some individuals in order to expand tax benefits for others.

This approach is found, for example, in plans developed by the Heritage Foundation, Mark Pauly of the American Enterprise Institute (AEI), and several 102nd and 103rd Congress bills. Some proposals view changes in the tax system as a way of restructuring incentives for health care consumers and providers. This approach is a central component of some of the "managed competition" plans now under discussion, such as the "Jackson Hole" and Conservative Democratic Forum plans. Changing consumer incentives is also important to proponents of medical savings accounts (MSAs), but with a different insurance market resulting than that envisioned under managed competition.

Two tax initiatives were incorporated in bills passed by the 102nd Congress but vetoed by President Bush. One would have extended the 25% deduction for self-employed businesses. The second would have allowed withdrawals from individual retirement accounts (IRAs) to pay for qualified medical expenses without incurring a tax penalty. Both are likely to be reconsidered in the 103rd Congress.

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## Most Recent Developments

President Bush vetoed H.R. 11, the Revenue Act of 1992, effective Nov. 5, 1992. This legislation contained provisions extending the 25% health insurance deduction for the self-employed (which expired June 30, 1992) and allowing penalty-free withdrawals from individual retirement accounts for medical expenses. Many bills to restore the 25% deduction and/or increase it to 100% have been introduced in the 103rd Congress. Other tax-based proposals to increase access to insurance to health insurance or contain health care costs have also been introduced.

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## BACKGROUND AND ANALYSIS

Numerous bills have been introduced in the 103rd Congress providing for changes in Federal tax law to promote financial access to insurance coverage and medical services or to contain health care costs. Some bills provide for incentives through credits and deductions. Others use tax penalties, such as limits on current-law credits or deductions, for failure to comply with certain requirements, such as providing health insurance benefits in excess of some specified limit. Still others, such as medical savings account proposals, allow individuals to set aside pre-tax earnings in special accounts to be used to pay for medical expenses. Many of these measures are stand-alone approaches to health care reform; others are part of broader initiatives.

President Bush's proposal to expand access to health insurance used refundable tax credits (combined with an expanded deduction for higher income persons) to encourage individuals to purchase insurance. The health care reform plan advanced by President Clinton during the 1992 campaign would provide tax credits and deductions to help offset the cost to small businesses of providing health insurance to their employees. So far, it looks like these measures will be in the plan President Clinton sends to Congress later this year.

Two tax-based health care initiatives were incorporated in bills passed by the 102nd Congress but vetoed by President Bush. One would have extended the 25% deduction for self-employed businesses. The second would have allowed withdrawals from individual retirement accounts (IRAs) to pay for qualified medical expenses without incurring a tax penalty. Efforts are likely to made early in the 103rd Congress to restore the 25% deduction for the self-employed. Other tax-based approaches to expanding coverage and controlling health care costs also will be among those seriously considered by the 103rd Congress.

## Current Federal Tax Laws

Under current law, the Federal Government provides incentives to employers to furnish health insurance by treating the cost of insurance as a deductible business

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expense and by excluding employer-provided benefits from taxable employee income. In addition, individuals may deduct medical expenses, including health insurance premiums, to the extent to which those expenses exceed 7.5% of adjusted gross income. Low-income families may also receive a tax credit for part of the costs of purchasing coverage for children.

**Employer Exclusion.** The Internal Revenue Code excludes from taxable income of workers all contributions made by employers on their behalf to health and accident plans. (Employer-provided health insurance would otherwise be treated as an alternative to wages and salaries and thus treated as taxable income.) Contributions are also excluded from the wage base for determining Social Security taxes.

**Employer Business Expense Deduction and Self-Employed Deduction.** Employers may deduct as an ordinary business expense 100% of the contributions made on behalf of their employees for health benefits. The self-employed whose businesses are not incorporated may deduct as a business expense the full cost of coverage for employees, but not for themselves and their families. Instead, the self-employed were, until June 30, 1992, provided a separate deduction on their tax returns, limited to 25% of the amounts paid for health insurance for themselves, their spouses, and their dependents when calculating their adjusted gross income for the taxable year. The deduction was not allowed if the self-employed person was also eligible to participate in any subsidized health plan of another employer or the employer of his/her spouse. The amounts deductible did not reduce the income base for computation of the self-employed individual's Social Security tax.

The 25% deduction for the self-employed was added to the Code by the Tax Reform Act of 1986 (P.L. 99-514) and was originally scheduled to apply only to tax years ending on or before Dec. 31, 1989. The deduction was repeatedly extended, but was allowed to expire in 1992. As passed by Congress, H.R. 4210, the Tax Fairness and Economic Growth Act of 1992, and H.R. 11, the Revenue Act of 1992, would have extended the deduction through June 30, 1993. However, both bills were vetoed.

**Health Insurance Tax Credit.** The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) created a small tax credit for low-income persons buying coverage for children. This tax credit is a supplement to the earned income tax credit (EITC), a "refundable" credit for families with children whose incomes are below $22,370 in 1992. If the EITC for a family is greater than the family's tax liability, the excess is payable to the family. Those who are eligible may also elect to receive advance payments over the course of the year, instead of waiting for a refund in the following year. The supplemental health insurance credit is available for families eligible for the EITC who buy coverage that includes qualifying children. The maximum credit is $451 for families with earned incomes below $11,840 in 1992; the credit is reduced as families approach the $22,370 income limit. Because the credit first became available only in 1991, there are not yet any estimates of the number of families taking advantage of it.

**Medical Expense Deduction.** Individuals who itemize deductions on their Federal income tax returns have been able to deduct nonreimbursed medical expenses (including insurance premiums) above a specified floor since 1942. From 1954 through 1982, the floor for the medical expense deduction was 3% of the taxpayer's adjusted gross income (AGI). A separate floor of 1% of AGI applied to nonreimbursed expenditures for medicine and drugs. Under the Tax Equity and Fiscal Responsibility

Act of 1982 (P.L. 97-248), the overall floor was increased to 5% of AGI, and was applied to the total of all eligible medical expenses, prescription drugs and insulin. The separate floor for medicine and drug expenses was eliminated. In addition, nonprescription drugs were made ineligible for the deduction. Under the Tax Reform Act of 1986 (P.L. 99-514), the floor for the medical expense deduction was increased to 7.5% of AGI, beginning in 1987. The deductions can be taken for medical care of the taxpayer and of the taxpayer's spouse and dependents. Thus, current law permits taxpayers to deduct the costs of health care that are, in effect, catastrophic as measured against family income.

**Federal Tax Expenditures.** The reductions in Federal revenues resulting from favorable treatment of certain types of private spending are often referred to as "tax expenditures;" the term reflects an assumption that the tax provisions achieve indirectly objectives that might also have been achieved through direct expenditure programs. Federal tax expenditures for the medical expense deduction and the exclusion of employer-provided benefits from employees' taxable income are projected by the Joint Committee on Taxation to total $49.5 billion in 1993. (This figure excludes lost Social Security payroll taxes, because higher collections now would mean higher benefit payments later.) The low-income health insurance tax credit will cost $0.7 billion. The self-employed health insurance deduction, if it had been extended at the 25% level, would have cost another $200 million. No estimates are available for the general employer business expense deduction for the costs of employee health benefits. Federal health-related deductions and exclusions may also affect the revenues of those State and local governments that impose an income tax and that follow the Federal system.

## Tax System Options for Health Care Reform

Proposals to modify the current tax treatment of health insurance have arisen in the context of the broader debate over how to provide health coverage to the uninsured (35.4 million in 1991) while controlling the growth in national health spending, projected to reach $808 billion, or 13.6% of gross domestic product, in 1992. Tax system changes may serve either of these two broad objectives. On the one hand, enhancement of existing deductions and credits could encourage individuals to purchase coverage or employers to provide it to their workers. On the other hand, limits on the favorable tax treatment already provided for health coverage could encourage restraint in personal health spending. While the two goals appear to be in conflict, many proposals embody both approaches, using savings from limiting tax benefits for some individuals in order to expand tax benefits for others. Some of these proposals view changes in the tax system as a way of restructuring incentives for health care consumers and providers. This approach is a central component of some of the "managed competition" plans now under discussion. It also underlies the design of plans that would establish MSAs.

### Measures to Encourage Insurance Coverage

Numerous proposals would create new Federal or State tax subsidies, or modify existing ones, to help individuals with the cost of health insurance (including, in some cases, the employee contribution required in most group health plans) or to encourage employers to provide coverage to their workers. Whether targeted at individuals or employers, tax incentive proposals rest on the assumption that assistance with the purchase of private insurance is preferable to direct public provision of health care coverage.

Proponents of this view believe that health care reform should build on the existing system of private coverage. They argue that a competitive private market is more likely than a government-operated system to promote efficiency and maintain quality. Those favoring public programs point out, however, that private insurance has high administrative costs (an average of 16.5% above medical benefits paid in 1990, compared to 2.1% for Medicare and 5.3% for Medicaid). Private insurers have expenses, such as marketing costs, that public programs do not incur, and must also build reserves and/or produce a profit for stockholders. These costs may be partially offset if private insurers are better able to control health care utilization or negotiate lower prices for medical services.

The goals met by tax subsidies could also be achieved through direct public grants to individuals or businesses to assist with the purchase of health coverage. The tax system provides a relatively simple way to transfer money to individuals and families. Tax subsidies could be administered using existing tax filing and refund procedures; they would not require the creation of new administrative agencies or procedures. However, new procedures would be required if, as in some tax credit proposals, assistance would also be provided on a means-tested basis to low-income persons who do not currently file tax returns.

**Individuals**

Tax incentives for the individual purchase of health insurance could take either of two forms: an expanded deduction (which reduces the amount of income subject to tax) or a credit (which directly reduces the amount of tax paid).

The current medical expense deduction provides assistance only to taxpayers who itemize deductions on their returns instead of taking the standard deduction. Except for homeowners, most low-income and some middle-income taxpayers derive no benefit from the deduction, because their other potential deductions are insufficient to raise the total to an amount greater than the standard deduction. One proposal would be to allow direct deduction of medical expenses by taxpayers who do not itemize. However, the benefits for lower-income families would still be limited. For those in the lowest tax bracket, the deduction would subsidize no more than 15% of their premium costs, and it would provide no assistance to families whose incomes are so low that they have no income tax liability.

For this reason, most tax incentive bills use a tax credit instead of a tax deduction (exceptions include H.R. 144 and H.R. 403). To ensure that assistance would be available to lower-income families, most proposals call for a refundable credit: if the amount of the allowable credit exceeds an individual's tax liability, the difference is payable to the individual.

A refundable tax credit for low-income taxpayers (combined with an expanded deduction for higher-income persons) was the centerpiece of the health care proposal advanced by President Bush in February 1992. The President's plan would have provided a maximum credit of $1,250 for individuals and $3,750 for families with incomes below the minimum subject to Federal income tax; the maximum credit would have declined as family income rose. Families eligible for the maximum credit could have received a voucher to purchase coverage over the course of the year, instead of waiting until the end of the year to claim a refund. Each State would have been required to ensure that at least some basic plan would be available within the State at a price no greater than the maximum credit amount. The Administration projected the total cost of the proposal to the Federal Government at $35 billion in 1997 dollars. Although this component of the President's proposal was never submitted to Congress, H.R. 5335 closely resembled the President's plan. Refundable tax credits were included in a number of other 102nd Congress bills, including H.R. 3951, H.R. 5989, S. 314, S. 454, S. 1936, S. 2095, and S. 2347. They are also in H.R. 196 and S. 28, introduced in the 103rd Congress.

Proposals similar to the Bush Administration plan may well receive further consideration in the 103rd Congress, and the issues raised by the plan remain of continuing interest in considering any tax credit approach toward expanding access to coverage. The first issue is that of adequacy: are the credits sufficient to encourage many individuals to purchase basic coverage? The Administration contended that market reforms and other cost containment proposals included in the plan would reduce the cost of insurance; critics of the plan argued that those assumptions were unrealistic and that larger subsidies were needed. They noted that the credit amounts phased down very rapidly with increasing income. It was not certain that low-income families receiving only a partial credit would be able or willing to make the additional expenditure needed to buy coverage. These concerns could be addressed by increasing the amount of the credits, but the cost to the Federal Treasury would also be increased. There is also a question of how much the credit amount should be allowed to grow in future years. If the credit keeps pace with growth in medical care spending, there may be no incentive for insurers or providers to improve efficiency; if the credit falls too far behind that growth, the value of the benefits it can purchase may decline from year to year.

A second question raised by tax credit plans is that of equity. Because health insurance costs vary by geography and by characteristics of the purchaser (such as age and sex), a fixed national credit amount might not allow all individuals to purchase comparable coverage. There may also be problems in targeting tax credits to avoid replacing existing public and private expenditures. Under the Bush Administration proposal, for example, some employers would have had incentives to reduce their contributions to premiums for low-income employees, because the employees could use credits to pay more towards their coverage. In addition, many poor individuals eligible for the maximum credit might have been shifted from Medicaid (with joint State/Federal funding) to a private plan purchased with the credit (solely Federal funding).

Finally, as was noted above, much of the amount distributed to individuals in the form of a credit would go to cover private insurers' administrative costs. For individually purchased coverage, these costs can be over 40% of benefits (compared to about [illegible] for the largest employer groups). The cost of a tax credit approach may therefore depend on whether the proposal includes some method for aggregating consumers into larger purchasing groups.

### Employers

Tax credits and deductions could also be used to influence employers' decisions regarding the purchase of health insurance. Such decisions can also be influenced through the use of tax penalties. For example, several 102nd Congress bills would have levied a sizable penalty on employer plans exceeding a specified basic benefit package (see H.R. 2565 and H.R. 5936.)

**The Self-Employed Tax Deduction.** The likelihood of receiving health insurance from an employer is highly associated with a firm's size and organizational structure. Coverage rates decrease as firm size decreases; coverage is least likely for firms with fewer than 10 employees where the owner is self-employed. Many believe that health insurance coverage rates are lower for self-employed businesses because the owner of the firm is limited to a 25% personal income tax deduction for the costs of buying insurance for himself and his family.

While many bills were introduced in the 102nd Congress to extend the 25% deduction and/or increase it to 100%, in the end Congress voted to extend the 25% deduction for another 12 months (July 1, 1992 through June 30, 1993) as part of the conference agreement for the Revenue Act of 1992 (H.R. 11). H.R. 11 bill was vetoed by President Bush for reasons having nothing to do with this provision. President Clinton indicated support for full deductibility during the 1992 campaign.

Early in the 103rd Congress, efforts are being renewed to restore the 25% deduction and/or to increase the deduction to 100%. Some bills phase in an increase in the deduction over several years; others provide for immediate full deductibility. Many proposals to increase the restore or increase the tax deduction are freestanding: they are solely intended to treat the deductibility of health care costs for self-employed businesses. Some are included in broader reform proposals. (See "Legislation" below.)

Proponents of full deductibility for self-employed firms argue that it would equalize the treatment of employer-sponsored health insurance. They say it is unfair that a self-employed person whose gross income includes most of the value of employer-paid health insurance has less after tax income than an employee with the same wages, other fringe benefits and expenses, but whose income does not include the value of any employer-paid health insurance. Opponents might respond that in the case of the self-employed, the employee is also an owner, and can therefore decide on how they will be compensated. Giving the self-employed a larger deduction for health benefits might encourage such owners to substitute tax-free health insurance for taxable wages. Also, providing the 100% deduction could encourage the purchase of richer ("Cadillac") insurance plans, thus driving up utilization of medical services and fueling inflation of health care costs. While this problem could be eased by limiting full deductibility to those plans that include but do not exceed some specified set of benefits, enforcing such limits could be problematic.

Proponents of full deductibility also argue that the 100% deduction would increase the incentive for self-employed businesses to buy insurance for their workers. The National Federation of Independent Businesses estimates, for example, that uninsured workers would decline by 25 to 50% as a result of increasing the deduction to 100%. Others are skeptical that this tax change would produce such a significant reduction in uninsured workers and their dependents. While over 20% of uninsured workers and their families are linked to self-employed firms, full deductibility might not induce large numbers of self-employed businesses to buy insurance for their employees. Many self-employed firms are unprofitable and have no tax liability to offset by a deduction that is not refundable. Also, changing the self-employed deduction only affects the taxable amount of income of the self-employed proprietor; it does not alter the tax treatment of premiums paid for employees' coverage. Because the after-tax costs for health insurance decline as the number of employees rise, full deductibility would most heavily benefit those firms where the proprietor is the only employee, and least benefit those with more than a few employees. Raising the deduction to 100% also raises budget issues. In March 1992, the Congressional Joint Committee on Taxation estimated that the cost of extending the deduction at its current level of 25% for one year is about $200 million; the cost of increasing the deduction to 100% is $1.7 billion for FY1994 and $1.2 billion for FY1995.

**Tax Credits for Small Businesses.** Some proposals would provide tax credits to employers to offset some of the cost of providing health insurance to their employees and their employee's families. (See 102nd Congress bills H.R. 5536, S. 1227, S. 1936 and S. 2114. The Clinton-Gore campaign proposal also included tax credits for small businesses.) Credits can be more effective than deductions in changing behavior because the amount of the credit does not necessarily depend on a firm having a tax liability. Eligible firms -- even those with no profits on which to pay taxes -- could still receive a credit to offset some portion of their employee health benefit costs. Tax credits can stand alone or be used in conjunction with other approaches to expanding coverage, such as pay-or-play proposals, private insurance market reform, or a combination of tax credits and deductions for individuals and businesses.

Different tax credit designs are possible, depending on the objective. Most are intended to ease the burden of providing health benefits on smaller employers, often defined as firms with 100 or fewer employees. Some bills draw the line at 50 employees, some at 25. The credit can be made available to all such small employers, only those newly providing health insurance, or those meeting specific requirements, such as those participating in a small employer purchasing group. If the credit were available to all small employers, private dollars now spent for coverage would be replaced by public dollars. If the credit were limited to currently uninsured firms, the public subsidy resulting from the tax credit would be more directly targeted on reducing the number of uninsured workers and their families. However, firms not receiving the credits because they already provided coverage could argue that they would be treated unfairly and could be placed at a competitive disadvantage. Some bills, such as S. 1227 in the 102nd Congress, further limit the availability of the tax credit to only those small firms for whom the cost of providing health insurance represents a significant financial obligation, measured either as a specified percentage of payroll or profits or some combination of both.

The design of the tax credit may also reflect other objectives such as encouraging the purchase of various types of insurance benefits and/or encouraging the containment of health care costs. Some proposals limit the tax credit for the purchase of qualified plans, meaning a specified benefit package, specified cost-sharing in the form of deductibles and coinsurance, a package that includes managed care elements, and/or some other feature that may be desired because of its effects on the cost or quality of care. Some proposals make the credit available on an ongoing basis. Others phase it out as other elements of the proposal take effect.

The effects of tax credits on coverage rates are unclear. Under a voluntary program in which the credits are used as an incentive for employers to buy coverage, much depends on the size of the subsidy provided through the tax credit, the cost of insurance, awareness of the credit, and other factors such as whether changes are made to the private insurance market to make insurance more available. State and local experiments using direct small employer subsidies such as tax credits to encourage the purchase of health insurance have produced only modest increases in coverage. Under a compulsory program, such as an employer mandate or play-or-pay requirement, the tax credits could offset some of the cost of providing coverage, thereby reducing adverse effects of the mandate on eligible employers and their employees.

## Options to Contain Costs and/or Finance Expanded Coverage

**Taxing Employer-Paid Health Insurance.** As noted above, when an employer pays part or all of the health insurance benefits or premium for an employee, the employee is not taxed on the employer's contribution. Instead, the contribution is wholly excluded from the employee's statement of wages and salary. The tax-free status of employer-paid health benefits has been credited with encouraging the growth of health plans offered through the work place, so that today, about 65% of the nonaged population is covered by employer-sponsored health insurance.

Some lawmakers and health policy experts have proposed the elimination of the exclusion (see S. 3348 from the 102nd Congress and "Heritage Foundation" below). Another possibility is to place a limit on the amount of contributions that can be excluded from an employee's taxable income (see, for example, H.R. 834 and S. 325 from the 103rd Congress). The limit is often referred to as a "tax cap."

Some advocates of eliminating or limiting the exclusion focus on the potential revenue gains, while others focus on the implications for health policy, contending that the current exclusion stimulates medical care inflation by encouraging excess insurance coverage. Opponents of changing the treatment of employer contributions argue that the loss in foregone revenues to the Federal Treasury ($46.4 billion in 1993) is far outweighed by the value of the benefits to employees.

There are at least two ways of limiting the tax exclusion for health benefits. One is to set a fixed dollar limit on employer contributions and tax any contribution in excess of that limit. Another option is to define a minimum standard benefit package and tax contributions to a plan whose benefits exceeded that standard. Either option could be applied to all taxpayers or limited to higher-income taxpayers. However implemented, a tax cap would theoretically change the way employees assessed the value of insurance coverage. The current exclusion has meant that each additional dollar of health benefits is worth more than a dollar of wages. As a result, workers negotiating a total compensation package may opt for more insurance than they would purchase if they had to use after-tax dollars. A tax cap might shift the balance back towards wages.

From a revenue standpoint, it would make no difference whether employees chose to continue receiving health benefits in excess of the tax cap or chose to convert the excess into wages. The Treasury would gain either way (but would not gain if workers shifted their health insurance dollars to some other form of tax-free compensation). From a health policy standpoint, however, the choice between wages and benefits is an important one. Would employees reduce their insurance coverage in response to a tax cap, and would any such reductions change the way they used medical services? Precisely because the current system has been in place for so long, there is little empirical evidence about how much coverage people would buy in the absence of a tax subsidy, or how they might change their coverage if pressured to reduce it. The effects of a tax cap on the medical care system are, then, less predictable than the effects on revenues.

**Limiting Employers' Deductions for Medical Insurance.** Another option would be to eliminate or cap the amount an employer is allowed to deduct as a business expense for providing employee health benefits. For example, in the 102nd Congress, H.R. 3892 would have denied the deduction to an employer's group health plan that discriminates against adopted children. H.R. 2264 would have denied the deduction for self-insured health plans that discriminate against services performed by chiropractors. S. 2346 and H.R. 5174 would have denied the deduction in the case of employer plans that do not meet specific benefit qualifications. S. 3348 would have limited the deduction to an overall per employee dollar amount. H.R. 191 in the 103rd Congress would deny the deduction for providing coverage in excess of a defined minimum benefit package. The effectiveness of reducing or eliminating the deductibility of premium contributions in influencing employers' decisions regarding health benefits would vary with the value of the deduction as well as other factors, such as the employer's need to provide comprehensive benefits to attract and retain employees.

**Medical Savings Accounts (MSAs).** A different cost containment approach is captured in bills providing for medical spending accounts (MSAs). (See, for example, 103rd Congress bills: H.R. 101, H.R. 150, and H.R. 192.) The MSA approach is based on the assumption that spending on health care is out of control because consumers are shielded from the costs of care by their health insurance plans, the direct costs of which are fully or partially paid by employers. (Indirectly, employees may be paying through foregone wage increases.) To sensitize consumers to the costs of care, they must be placed in the position of paying directly for that care.

Under most MSA proposals, employers would be allowed to pay the amounts they currently spend on employee health benefits directly to their employees. This amount would not be included as taxable wages to the employee, and would be deductible by the employer as a normal business expense. Employees would then set up their own MSAs and buy their own insurance policies. Workers and their families could use their MSAs to pay for all routine medical services; any unused funds could remain in the account, collecting interest (usually tax-free), and withdrawn later to pay for medical expenses. Funds withdrawn for other purposes would be treated as taxable income (much like early withdrawals for individual retirement accounts). Insurance policies would only cover catastrophic medical expenses, defined as expenses in excess of a specified threshold. Some MSA proposals would also provide federal subsidies to those in need to assist them in buying the catastrophic insurance.

In addition to containing costs, proponents of the MSA approach say that it would make insurance more portable than today's employer-sponsored health plans, because employees could, in effect, take their accounts with them. Moreover, employers would no longer have to bear the administrative burdens of setting up health plans, negotiating with insurers, and/or paying claims. Their principal role would be a financial one: to make contributions to employees' MSAs. Also, MSAs could provide greater benefit flexibility than typical employer-sponsored health plans. Employees would not be limited to one or a few insurance plans offered by an employer. They would instead have the entire market of insurers and their catastrophic plans from which to choose.

Opponents of MSAs say that their cost containment potential is greatly overstated. They argue that the consumer has relatively little influence over the intensity and volume of medical services. It is, instead, the physician who makes the most critical buying decisions. Also, they say, it is not clear whether many consumers are willing to buy the economy model of medical care. They might prefer the more expensive physician or hospital, making an assumption that cost and quality are linked. Another problem is that under the MSA approach, individuals do not have the bargaining power to obtain the kinds of discounted rates that are negotiated by large employers and insurers with providers. Some critics also argue that MSAs are incompatible with managed care arrangements, such as health maintenance organizations (HMOs), and thus go against effective cost containment. HMOs, for example, try to control costs by managing care from the time the patient enters the health care system. By the time catastrophic coverage is needed -- the point at which insurance is triggered under the MSA approach -- it is too late in the episode of care to manage.

Opponents also question other claims made by MSA advocates. They say that while the MSA itself might be portable, the source of financing would still be employer-dependent, and thus unpredictable. Some employers might not contribute; others might make inadequate contributions. Another concern is that the MSA approach moves people out of group insurance into the more expensive and less reliable individual insurance market to buy catastrophic policies. This could cause significant disruptions in coverage. Finally, opponents argue that because the MSA approach only shifts current employer dollars from one system to another, it appears to do nothing to expand access to coverage for America's 35 million uninsured, and could lead to increased numbers of uninsured if the solvency of MSA accounts were dependent upon the continuity of employer contributions.

## Tax Incentives and Competitive Approaches to Universal Coverage

Numerous proposals have been advanced that combine limits on the favorable tax treatment of employer-provided coverage with subsidies (whether or not tax-based) for the purchase of individual coverage. Several bills in the 102nd Congress adopted this approach, including H.R. 5936 (Representative Cooper, the Conservative Democratic Forum or CDF proposal), H.R. 5989 (Representative McEwen), and S. 3348 (Senator Hatch). It is also incorporated in S. 223 (Senator Cohen), introduced in the 103rd Congress. Similar proposals have been developed by trade associations, academics, and others. Among the more widely discussed are the Jackson Hole plan (by Alain Enthoven, Paul Ellwood, and Lynn Etheredge), a plan by Mark Pauly and his colleagues (sometimes referred to as the American Enterprise Institute or AEI proposal), and the Heritage Foundation plan.

All these proposals assume that the existing tax treatment of employer-provided health insurance creates inequity in the government subsidization of health care costs (because the tax benefits increase with income) and fuels health care inflation by shielding individuals from the costs of their medical care purchasing decisions. By shifting some or all Federal assistance (whether tax or non-tax) away from employer-based plans and towards individuals, they seek to ensure that every American has basic health coverage, regardless of employment status. (They may also address "job lock," workers' reluctance to change jobs because of a fear of losing health benefits.) However, the major focus of the competition proposals is on cost containment: they seek to encourage individuals to be cost-conscious in their choice of health insurance and/or in their use of medical services by giving them a more direct financial stake in those decisions. All the plans assume that, if consumers are given a financial stake in their health care purchasing decisions, the market will respond: health care providers and/or insurers will compete on the basis of price and quality.

Proposals to restructure financial incentives and promote competition have been debated for many years. For example, Ellwood and Enthoven each advanced early versions of their current proposal in the 1970s. Several basic concerns have been raised about the competitive approach in the past. First, individual consumers may not have sufficient information or sophistication to compare the relative quality of different health plans; even price comparisons may be complicated if different insurers offer different benefit packages. Second, insurers may be able to compete, not on the basis of quality or efficiency, but on the basis of their ability to attract low-cost enrollees and screen out those presenting higher risks (by rejecting some individuals, imposing waiting periods for coverage of preexisting conditions, or charging high-risk enrollees prohibitive premiums). Third, as was noted earlier, administrative costs for individual coverage are much higher than for group coverage, and may offset any expected savings from competition.

Each of the proposals attempts to address some or all of these concerns. All the plans call for a uniform minimum benefit package, to facilitate comparison among competing insurers. All except the Heritage and Pauly proposals would regulate insurance underwriting practices, to limit the ability of insurers to screen out high-risk applicants. (Pauly suggests, in lieu of regulation, that higher-risk individuals might be given more tax assistance to meet the higher premiums they would have to pay.) The Jackson Hole and CDF plans go further, proposing the development of structured systems for what they term "managed competition." (See CRS Issue Brief 93008, *Health Care Reform: Managed Competition*, by Mark Merlis.)

Under managed competition, employers or other purchasers of health insurance would be grouped together in cooperative buying arrangements known as health insurance purchasing corporations or cooperatives (HIPCs). Individuals participating in the arrangement would have a choice among different health care plans and would be given a financial incentive to select the least costly plan. Plans would have uniform benefits, so that in theory any price differences would reflect relative efficiency. Proponents of this approach assume that the less costly plans would resemble health maintenance organizations (HMOs), which provide care through a restricted network of affiliated providers. Consumers wishing to select a less restrictive and more costly plan would have to pay the added costs from their own funds, without tax assistance. (It should be noted that not all managed competition plans involve tax system changes. Senator Bingaman's proposal (S. 3300 in the 102nd Congress) and draft President-elect Clinton's campaign proposal used other means to encourage the choice of efficient plans.)

Critics of this approach argue that the evidence of savings from managed care is limited and that systems offering multiple choices of plans may be subject to "biased selection." All the young and healthy people may wind up in HMOs or other restrictive plans, while the older and sicker enrollees stay with the conventional plan and continue to incur high costs. Proponents of managed competition suggest adjusting premium rates to correct for this problem; however, it is not yet certain that adequate methods are available. (For a full discussion of the cost-saving potential of managed care, see CRS Report 90-64, *Controlling Health Care Costs*.)

The following is a brief summary of the major tax-based plans advanced to date.

**Heritage Foundation plan.** Under the Heritage plan, the existing tax exclusion for employer contributions for health insurance would be phased out and replaced with refundable tax credits, the amount of which would be tied to a family's income, insurance premiums, and other health care expenses. Credits could be used both for insurance premiums and for payment of out-of-pocket expenses. Lower-income families with high medical expenses would be most favored by the credits; high-income families with low medical expenses would be least favored. All Americans would be required to enroll in a health insurance plan containing Federally prescribed benefits, including coverage for catastrophic expenses, hospital and physician services, and routine preventive care. Plan deductibles and coinsurance could not exceed 10% of a family's income and would be offset by the tax credits. Medicare would be continued for the elderly and disabled, Medicaid for eligible low-income persons.

**Pauly plan.** The Pauly (or AEI) plan also repeals the tax exclusion of employer-provided health benefits and provides income-based tax credits to assist individuals in purchasing plans providing minimum federally specified benefits. There are at least four major differences between this and the Heritage plan. First, employers would be required to perform some administrative functions to facilitate employees' purchase of coverage. Second, tax credits could be used only to subsidize premiums and not to pay for medical services. Third, cost-sharing requirements under the minimum benefit package would be inversely related to enrollees' income. Finally, the amount of tax credits might be adjusted to reflect the level of health risk presented by each individual, in order to reduce the incentives for insurers to exclude potentially costly applicants.

**H.R. 5989/S. 3348 (102nd Congress).** The McEwen-Hatch proposal resembles the Heritage plan: it phases out the employer exclusion and provides a tax credit that can be used both for purchase of a basic health plan and for direct payment of medical expenses. However, the size of the credit is not related to income, and the maximum amount is limited to 80% of the first $275 in premiums per person, 18% of remaining premiums, and 18% of health care costs not covered by health insurance. The bill includes stronger measures than the Heritage and Pauly proposals to ensure that coverage will be available to individuals receiving the credit. States would be required to establish programs to provide coverage (with income-related premiums) for the uninsured; the bill also includes regulation of underwriting and rating practices of small group insurers.

**Jackson Hole plan.** The Jackson Hole proposal would limit the employer exclusion to the cost of the lowest-priced plan available through the HIPC in the area (whether or not the employer's plan was actually purchased through the cooperative). Employers would be required to contribute towards coverage of their full-time workers and dependents; any difference between the employer's contribution and the total premium for the lowest-priced plan would be deductible for the individual. Non-tax system government subsidies would be available to help persons without employer coverage purchase a HIPC plan.

**H.R. 5936 (102nd Congress).** The CDF proposal is based on the Jackson Hole plan, but differs from it in at least two key features. First, employers would not be required to contribute towards employee coverage. Second, instead of limiting the exclusion of employer contributions from employees' taxable income, the plan imposes a tax penalty on an employer whose contributions exceed the cost of the lowest-price HIPC plan.

## LEGISLATION

Please note that many of these bills include more than tax system changes.

**H.R. 30 (Grandy)**
Universal Health Benefits Empowerment and Partnership Act of 1993. Provides for phase-in of 100% deductibility for self-employed. Introduced Jan. 5, 1993; referred to Committees on Education and Labor, Energy and Commerce, and Ways and Means.

**H.R. 101 (Michel)**
Action Now Health Care Reform Act of 1993. Provides for phase-in to 100% deduction for self-employed and allows tax-free employer contributions to MSAs. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, Judiciary, and Education and Labor.

**H.R. 144 (Cox)**
Provides for full deductibility for individuals of unreimbursed medical expenses. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Judiciary, and Energy and Commerce.

**H.R. 150 (Hastert)**
Health Care Choice and Access Improvement Act of 1993. Allows a tax deduction for contributions to MSAs and for premiums for a catastrophic health insurance policy; expands the self-employed deduction to 100% and makes permanent. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Judiciary.

**H.R. 191 (Gekas)**
American Consumers Health Care Reform Act of 1993. Taxes employer health benefits in excess of a minimum benefit package and provides 100% deduction for self-employed for costs of that package. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, Education and Labor, Judiciary, and Rules.

**H.R. 193 (Gunderson)**
Farm and Rural Medical Equity Reform Act of 1993. Allows a tax deduction for contributions to MSAs and for premiums for a catastrophic health insurance policy. Provides for 100% deduction for self-employed. Introduced Jan. 5, 1993; referred to Committees on Ways and Means and Energy and Commerce.

**H.R. 196 (Houghton)**
Health Equity and Access Improvement Act of 1993. Creates refundable health insurance tax credit, makes insurance fully deductible for individuals; restores 25% deduction for self-employed. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Judiciary.

**H.R. 200 (Stark)**
Health Care Cost Containment and Reform Act of 1993. Restores 25% deduction effective July 1, 1992 and increases to 100%, effective for taxable years after Dec. 31, 1993. Introduced Jan. 5, 1993; referred to Committees on Ways and Means, Energy and Commerce, and Education and Labor.

**H.R. 264 (McCandless)**
Increases and extends the self-employed deduction. Introduced Jan. 6, 1993; referred to Committee on Ways and Means.

**H.R. 403 (Solomon)**
Permits tax deduction for up to $3,000 in health insurance premiums without regard to current requirement that medical expenses are deductible only when they exceed 7.5% of adjusted gross income. Introduced Jan. 5, 1993; referred to Committee on Ways and Means.

**H.R. 577 (Bereuter)**
Provides for 50% deduction for self-employed and makes it permanent, effective for taxable years beginning after Dec. 31, 1991. Introduced Jan. 26, 1993.

**H.R. 679 (Holden)**
Restores the 25% self-employed deduction, effective for taxable years beginning after Dec. 31, 1991; increases deduction in phases so that it reaches 100% for 1997 and thereafter. Introduced Jan 27, 1993; referred to Committee on Ways and Means.

**H.R. 815 (Barrett)**
Increases and extends the self-employed deduction. Introduced Feb. 4, 1993; referred to Committee on Ways and Means.

**H.R. 836 (Hutchinson)**
Restores 25% deduction for self-employed effective for taxable years after Dec. 31, 1991, and increases deduction to 100 effective for coverage after June 30, 1992. Introduced Feb. 4, 1993; referred to Committee on Ways and Means.

**H.R. 912 (Peterson)**
Increases and extends the self-employed deduction. Introduced Feb. 16, 1993; referred to Committee on Ways and Means.

**S. 18 (Specter)**
Comprehensive Health Care Act of 1993. Provides for 100% deduction for self-employed, effective for taxable years after June 30, 1992. Introduced Jan. 21, 1993; referred to Committee on Finance.

**S. 25 (McCain)**

Children's Health Care Improvement Act of 1993. Establishes refundable tax credit for health insurance expenses of children in families below 200% of poverty; the credit may be used only for school-based insurance programs established by States and localities. Introduced Jan. 21, 1993; referred to Committee on Finance.

**S. 223 (Cohen)**

Comprehensive Health Care Act of 1991. Taxes employer health plan contributions in excess of lowest-priced Accountable Health Plan (AHP) in the area. Provides refundable tax credit for individuals purchasing AHP coverage. Increases self-employed deduction. Introduced Jan. 27, 1993; referred to Committee on Finance.

**S. 325 (Kassebaum)/H.R. 834 (Glickman)**

Provides for 100% deduction for self-employed; disallows employer exclusion, business deduction, and nonreimbursed individual medical expenses deduction for premiums paid for plans that are not BasicCare health plans. Allows an individual to deduct unreimbursed premiums paid for a BasicCare health plan, regardless of whether the taxpayer meets the 7.5% AGI threshold. Introduced Feb. 4, 1993; S. 325 referred to Committee on Finance; H.R. 834 referred to Committees on Energy and Commerce, Ways and Means, Judiciary, Education and Labor, and Rules.

**S. 339 (Baucus)**

Provides for 25% deduction for self-employed for the 6-month period ending Dec. 31, 1992. Feb. 4; referred to Committee on Finance.

**S. 360 (Dorgan)**

Phases in 100% deduction for self-employed. Introduced Feb. 16, 1993; referred to Committee on Finance.

## FOR ADDITIONAL READING

Butler, Stuart M. A Tax Reform Strategy to Deal with the Uninsured. Journal of the American Medical Association. May 15, 1991, v. 265, no. 19, p. 2541-2544.

Pauly, Mark V., et al. Responsible National Health Insurance. Washington. The AEI Press. 1992.

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# CRS Report for Congress

# The Canadian Health Care System

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February 20, 1990

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# THE CANADIAN HEALTH CARE SYSTEM

## SUMMARY

Canada has provided universal health insurance coverage to its legal residents since 1972 through health insurance programs jointly financed by the Federal Government and the 10 provincial and 2 territorial governments. Provincial and territorial authorities design their own programs according to Federal standards. Each program must ensure that: individuals have access to needed medical services without regard to cost; benefit packages include all medically necessary hospital and physician services; all residents of a province are covered; insurance coverage is continued when Canadians travel from one province to another; and insurance plans are administered on a non-profit basis by a public authority.

While administration of the health insurance program is primarily a provincial responsibility, the Federal Government provides block grants to the provinces to help defray the cost. Without regard to individual provincial health expenditures, provinces and territories receive an equal per capita contribution from the Federal Government, adjusted annually to take into account increases in Gross National Product.

In general, health services are provided through the private sector. However, provinces have the authority to determine the method and rate of reimbursement for health care providers. Most Canadian hospitals receive funds under global budgets. With the exception of hospital-based physicians who are salaried employees of the hospitals, most physicians are paid on a fee-for-service basis. The fee schedule is determined on the provincial level by negotiations between public authorities and professional associations representing the health care practitioners.

The provincial health systems do not limit care for life-threatening conditions. However, restraints placed on hospitals budgets and limits on the number of specialty physicians have produced waiting lists for some elective services. Systematic data on waiting times are not available but anecdotal reports indicate that waiting lists exist for some procedures in each province but that the times and procedures vary by province.

Analysts have pointed to both advantages and disadvantages of the Canadian system when compared to the U.S. health care system. Canada has achieved universal coverage of its population while spending about 38 percent less per capita on health than the United States. On the other hand, some forms of medical technology are less available in Canada, there is less innovation in the delivery and financing of health care, and the lack of cost-sharing requirements appears to encourage excess utilization. Both countries face difficult financing and service delivery problems as aging populations, technology changes and increases in the volume and intensity of services continue to fuel costs.

## THE CANADIAN HEALTH CARE SYSTEM

### INTRODUCTION

Since 1972, Canada has provided universal health insurance coverage to its legal residents through health insurance programs jointly financed by the Federal Government and provincial and territorial authorities.[1] The health insurance program evolved in a series of steps, beginning with the initiation of universal hospital insurance by the western province of Saskatchewan in 1946. In 1957, the Federal Government encouraged the expansion of hospital insurance programs in all the provinces and territories by providing cash subsidies to jurisdictions that instituted qualified plans. In 1962, a similar program was instituted to cover physician care and other medical services. All of the provinces and territories had adopted qualified plans by 1972.

In 1987, Canadian health care expenditures accounted for 8.6 percent of gross national product (GNP). This represented expenditures of approximately $1,483 per capita, making Canada second only to the United States in this category. The public sector in Canada accounted for approximately 75 percent of these payments compared to 41 percent in the U.S.

### Coverage

Currently, all legal residents of Canada are covered by one of the nation's 10 provincial or 2 territorial health insurance plans. Local authorities design their own health insurance programs following Federal standards, codified in the Canada Health Act of 1984. According to these guidelines, provincial plans must meet the following criteria in order to qualify for full Federal cash contributions to their programs:

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[1] Unless otherwise noted, general information on the Canadian health care system is derived primarily from: Canada. Ministry of Health and Welfare. Health Insurance Directorate. Health Services and Promotion Branch. *Overview: The Canadian Health Care System.* Ottawa, May 1988; Canada. Ministry of Health and Welfare. *1987-1988 Canada Health Act Annual Report.* Ottawa, 1988; Employee Benefit Research Institute. *Canada's Health Care System: Lessons for the United States?* Issue Brief number 90, May, 1989; Lomas, Jonathan, et al. Paying Physicians in Canada: Minding our Ps and Qs. *Health Affairs*, Spring 1989, p. 80-102. Data derives from Canada. Policy, Planning and Information Branch. Ministry of Health and Welfare. *Health Sector In Canada: Fact Sheets.* Ottawa, 1989; Schieber, George J., and Poullier, Jean-Pierre. International Health Care Expenditure Trends: 1987. *Health Affairs*, fall 1989, p. 169-177.

- The insured population must have access to needed medical services without regard to cost. To ensure that patients are not forced to forego care because of out-of-pocket medical expenses, user charges and extra-billing[2] may not be imposed.[3]

- Benefits offered by insurance plans must be comprehensive, including medically necessary services provided by hospitals and physicians.

- All residents of a province must be entitled to insured health services. A waiting period prior to entitlement by residents may not exceed 3 months.

- Canadians moving from one province to another must continue to be covered for insured health services by their home province during any waiting period imposed by their new province of residence. Medical care for residents of one province who are temporarily visiting another province is reimbursed under the insurance plan of the patient's home province.

- Provincial health insurance plans must be administered and operated on a non-profit basis by a public authority.

**Benefits**

All of the provincial and territorial health insurance plans must cover medically necessary hospital services, physician services and certain surgical dental procedures. There are no dollar limits to the amount of necessary medical care that individuals may receive. All plans include the following benefits:

- In-patient hospital care including accommodations and meals at the standard ward level, nursing services, necessary drugs, medical and surgical supplies and diagnostic tests.

- Out-patient hospital services including emergency visits, laboratory, radiological and other diagnostic procedures.

- Physician services including all medically necessary services performed by medical practitioners in hospitals, clinics or physicians' offices.

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[2] Extra-billing occurs when physicians charge patients an additional amount above the fee negotiated by the province with physicians collectively.

[3] Provinces are not forbidden by law to impose user fees or extra-billing but are subject to dollar-for-dollar deductions from Federal contributions to their health insurance programs if they permit these practices.

Provinces are not required to insure residents for the costs of eyeglasses, outpatient prescription drugs, general dental care and semiprivate or private hospital accommodations. However most provinces include an outpatient prescription drug benefit for the elderly and individuals who qualify for public assistance.

The Canada Health Act does not specify what benefits are required in a comprehensive program. Additionally, all provinces and territories may include additional benefits that are not required under the national guidelines. For example, Ontario, the largest province, includes mental health services, ambulance services, the services of chiropractors, osteopaths, chiropodists and approved physiotherapy clinics within its benefit structure. It also provides a drug benefit program for the elderly and individuals receiving public assistance.

Coverage of long-term care is not required under the Canada Health Act. However the Federal Government does make an equal per capita contribution to the provinces and territories in support of nursing home care, home care and ambulatory health care. These payments are not contingent on conformity to the standards required in the general health insurance program and provinces are free to structure their long-term care program as they see fit. As a result, there is significant variation in the type and amount of long-term care provided under provincial plans.

## Financing

The health insurance system is financed jointly by the Federal and provincial and territorial governments. When the national health insurance program was first instituted, the Federal Government reimbursed local authorities for 50 percent of the insurred cost of health care services. However after passage of the *Federal-Provincial Fiscal Arrangements and Established Program Financing Act* in 1977, Federal fiscal contributions to the health insurance program were restructured into a block grant approach.

Without regard to individual provincial health expenditures, provinces and territories receive an equal per capita contribution from the Federal Government, adjusted annually to take into account increases in nominal GNP. The Federal share takes the form of tax transfers to the provinces and cash subsidies derived from general revenues. Provinces may use the Federal monies within their health insurance programs as they see fit as long as the Federal criteria are met.

While they cannot impose user fees or extra-billing without losing Federal financial support, provinces have considerable latitude in determining how their share of health care costs are financed. They may institute insurance premiums, sales taxes, use general revenues or utilize a combination of approaches. All provinces and territories use general tax revenues to support most of the costs of their insurance programs. In addition, Ontario, British Columbia and Alberta impose a small payroll tax premium to raise a portion of the required sums. Premiums reflect family size but not risk status. However, the elderly and all those who qualify for public assistance are exempt from the premium. Additionally, failure to pay the required premium does not result in loss of access to needed medical services.

Health insurance is the single largest program funded by the provincial governments, but there is considerable variation in the amount of resources that each jurisdiction devotes to health care and the rate by which health care costs are increasing. Health care expenditures ranged from approximately 30 percent of gross provincial expenditures in Ontario in 1985 to 20 percent of gross provincial expenditures in Newfoundland in the same year. In the period from 1983 to 1987, per capita spending on health care increased by 41 percent in Ontario, and 33 percent in Nova Scotia compared to 13 percent in Alberta and 18 percent in British Columbia.

Since the inception of the block grant formula, Federal contributions as a percentage of the total cost of the Canadian health care system have gradually decreased. In 1988, the last year for which figures are available, 30.4 percent of health care expenditures were financed by the Federal Government, compared to 42.2 percent of the costs borne by the provincial governments. Private sources were responsible for 25.4 percent of all health care expenditures (see figure 1).[4]

## Administration

The responsibility for administration of the Canadian health care system lies with the provincial and territorial governments. Federal standards require that the health insurance program be administered by a public non-profit authority. Although private insurance companies exist, they are not permitted to cover services provided under the provincial plan. Thus, for all covered benefits, the government is the sole payer. When services are provided on a fee-for-service basis, bills are sent directly to the provincial authority.

The cost of administration has been kept low. It is estimated that administrative costs account for approximately 1.5 to 2.5 percent of Canadian health expenditures, compared to 6 to 8 percent of U.S. health expenditures.

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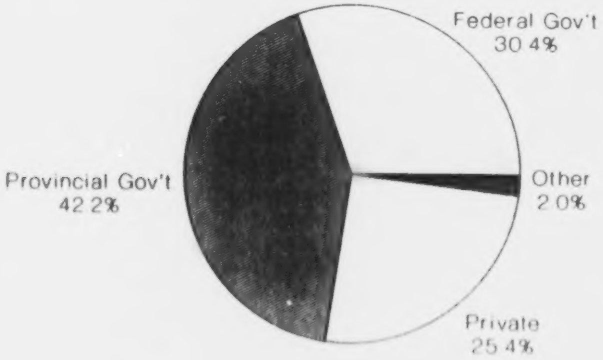
[4] Policy, Planning and Information Branch. Ministry of Health and Welfare. *Health Sector in Canada: Fact Sheets*. Ottawa, 1989. p. 2.

Figure 1. Health Financing
in Canada by Source of Funds
1988



**Canadian Government, Ministry of Health Policy, Planning and Information Branch, 1989.**

**Reimbursement Methods**

Provinces have the authority to determine the method and rate of reimbursement for health care practitioners. A distinction is made between remuneration for hospitals and physicians.

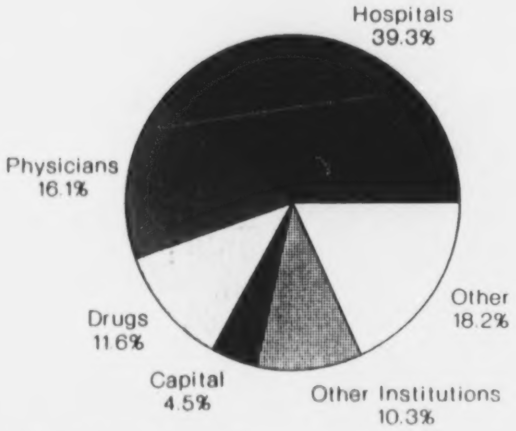
Hospitals accounted for 39.3 percent of total Canadian health care expenditures in 1988. (See figure 2 for the composition of Canadian health care expenditures). Most Canadian hospitals receive funds under a global budgeting system. Annually, hospital administrators negotiate an operating budget with the provincial authorities. Budgets are meant to take into account bed to population and staff to patient ratios, as well as changes in the mix and volume of services provided. Allocation of resources is then the responsibility of the individual hospital administrators.

Capital budgets are determined separately. New facilities, equipment, major hospital renovations and other capital expenditures have to be approved by the Ministry of Health in each province. Provinces vary in the extent to which they fund capital improvements. However all hospitals are required to fund some of these costs themselves. Methods range from community-wide fund raising drives to the issuance of municipal bonds.

Most physicians are paid on a fee-for-service basis. Fee schedules are determined on the provincial and territorial level by negotiations between public authorities and professional associations representing the health care practitioners. These professional associations are also responsible for allocating funds between specialty groups. Alternately, most hospital-based physicians are salaried employees of the hospitals. Payment for physician services accounted for 16.1 percent of total health expenditures in 1988.

The provinces have instituted various methods in an attempt to control the level of expenditures for physician services. Since the inception of national health insurance in Canada, health care utilization has increased at an annual rate of almost 4 percent. Five provinces--Ontario, British Columbia, Saskatchewan, Manitoba, and Quebec--have incorporated measures aimed at controlling the volume of physician services into their fee schedules. Most of these provinces utilize some form of expenditure target by which excessive increases in the volume of services provided patients result in a reduction in payments in the next negotiated fee schedule. In contrast, Quebec applies a quarterly cap to individual physician incomes. When the fixed ceiling has been reached, further payments are reimbursed at a significantly lower level during the remainder of the quarter.

Figure 2. Composition of Canadian Health Expenditures 1988



Canadian Government: Ministry of Health Policy, Planning and Information Branch, 1989.

## Provision of Care

In general, health care services are provided through the private sector. The majority of Canada's hospitals are owned and operated by non-profit entities including municipalities, voluntary agencies and religious groups. While these institutions employ some physicians, the majority of the medical staff is composed of private physicians granted admittance privileges by the facilities.

In 1988, there were 4.36 short-term hospital beds per 1,000 persons with an average occupancy rate of 85.5 percent. Average length of stay was 14.14 days.

While about 25-30 percent of physicians are salaried employees of hospitals or clinics, the majority of practicing physicians are private practitioners reimbursed according to a provincial-wide negotiated fee schedule.[5] Patients are free to choose their physicians and physicians have the option of accepting or refusing any patient.

As of 1988, there were 57,405 active physicians in Canada, a ratio of one physician per 451 persons. Of these, 26,079 or 45 percent were general practitioners or family physicians, and 23,627 or 41 percent were specialists. The remainder were interns and residents.

## Rationing

The provincial health systems do not limit care for life-threatening conditions. However, restraints placed on hospital budgets and limits on the number of specialty physicians have produced rationing "by the queue"--waiting on line--for some elective services. In addition, specific high-technology equipment such as magnetic resonance imagers (MRI) and lithotripters are explicitly controlled by the provincial governments, and are generally restricted to hospitals.[6]

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[5] Physicians have the option of practicing completely outside the national health insurance scheme but they cannot take some patients covered by the plan and others as private pay patients.

[6] Evans, Robert G., et al. Controlling Health Expenditures-The Canadian Reality. *The New England Journal of Medicine*, Mar. 2, 1989. p. 571-577. Kosterlitz, Julie. Taking Care of Canada. *National Journal*, July 15, 1989, p. 1792-1797. Linton, Adam. The Canadian Health Care System: A Canadian Physician's Perspective. *The New England Journal of Medicine*, Jan. 18, 1990. p. 197-199. Walker, Michael. From Canada: A Different Viewpoint. *Health Management Quarterly*, first quarter, 1989.

As the table below shows, Canada has less high-cost technological equipment on a per capita basis than the United States.

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**Availability of Selected Medical Technologies: Canada and the U.S.**[a]

| | Canada (1988-9) | U.S. (1987) |
|---|---|---|
| | Units per million | |
| Open-heart surgery | 1.23 | 3.26 |
| Cardiac catheterization | 1.50 | 5.06 |
| Organ transplantation | 1.08 | 1.31 |
| Radiation therapy | 0.54 | 3.97 |
| Lithotripsy | 0.16 | 0.94 |
| Magnetic resonance imaging | 0.46 | 3.69 |

[a] Rublee, Dale. Medical Technology in Canada, Germany, and the United States. *Health Affairs*, fall 1989.

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As a result of constraints on equipment supply, waiting lists exist for access to some types of equipment and procedures. Systematic data on waiting times are not available but anecdotal reports indicate that waiting lists exist for some procedures in each province but that the times and procedures vary by province. For example, in Newfoundland, which has a population of 570,000, there was one functioning CAT-scanner team in early 1989. This created a 2 month waiting time for a scan. In the same province, there was a 2.5 month waiting list for a mammogram, a 1 to 1.5 month wait for bone scans, and a 6 to 10 month wait for hip replacements. However, in Alberta, where at the same time there was excess hospital capacity, no major queuing problems existed.[7]

Rationing of elective services by triage (limiting care on the basis of priority of need and proper place of treatment) is not explicit government policy. For example, the provincial plans do not place an age limit on insurance coverage for organ transplants or other high-cost, high-risk procedures. However, such factors may enter into physicians' clinical judgments just as they do in the United States. A recent study comparing hospital stays and medical and surgical treatment of elderly Canadian and U.S. patients with diseases of the circulatory system found that while elderly Canadian patients had less access to coronary bypass surgery, they had greater access to "other complex and potentially beneficial procedures."[8]

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[7] Walker, Michael A. From Canada: A Different Viewpoint. *Health Management Quarterly*, first quarter, 1989. p. 11-14.

### Physician Satisfaction

Although conflicts with provincial governments over fee negotiations have led to several physician strikes, and physicians express concerns about underfunding for hospitals and technology, the medical profession is reportedly largely supportive of the Canadian system. Physicians are free to make individual medical decisions for their patients without direct interference. They are also largely unencumbered by the types of constraints on practice faced by their U.S. colleagues, such as utilization review, second opinions, and managed care. However, because of the increasing volume of services provided by physicians (partly in response to the limits on fees), the provincial governments are expected to try to impose limits on the number of services for which they will pay. In addition, some provinces are beginning to experiment with capitated delivery systems.[9] They also are looking to the United States for methods of encouraging more appropriate and effective medical care.

Canadian physicians enjoy relatively high incomes. In Ontario, the 1984 income of physicians was about five times that of the average industrial worker. For the same period, U.S. physicians' incomes was about 5.5 times the average industrial wage. Canadian physicians maintain larger average net incomes (after professional expenses but before taxes) than those of dentists, lawyers, accountants, engineers and architects.[10]

### Canada-United States Comparisons

The health care systems of Canada and the United States have much in common: Providers of care, including physicians and hospitals, are largely private. The majority of patients in both systems receive care on a fee-for-service basis and are free to choose their own providers. Medical education is so similar in structure and curriculum that U.S. graduates of Canadian medical schools are not considered to be "foreign medical graduates" when they return to the U.S. Both systems are heavily oriented to diagnosis and cure, as opposed to disease prevention and health promotion. Similarly, both systems have problems with an undersupply of physicians in remote areas but an oversupply of certain specialists. In addition, health care costs in Canada and the United States are climbing at about the same rate, and both countries face difficult financing and service delivery problems as aging populations, technology changes, and increases in the volume and intensity of services continue to fuel those costs.

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[8] Anderson, Geoffrey M., Joseph Newhouse and Leslie Roos. Hospital Care for Elderly Patients With Diseases of the Circulatory System. A Comparison of Hospital Use in the United States and Canada. *New England Journal of Medicine*, Nov. 23, 1989. p. 1443-1448.

[9] Capitation is a method of paying for an individual's medical care through a per capita payment that is independent of the number of services received or the costs incurred by providers in furnishing those services.

[10] Iglehart, John. Health Policy Report. Canada's Health Care System. Part 1. *The New England Journal of Medicine*, July 18, 1986. p. 202-208.

There are also a number of ways in which the Canadian and U.S. systems are different. Compared to the system in the U.S., the Canadian system has some drawbacks: some forms of medical technology are less available, there is less innovation in the delivery and financing of health care, and the lack of cost-sharing requirements appears to encourage excess utilization. Some analysts also point to Canada's longer average hospital stays and heavier reliance on institutionalization to care for the elderly as indicators of greater inefficiency.

There are, however, some features of the Canadian system which have been admired by U.S. observers. Although problems exist in obtaining access to some services, Canada has achieved universal coverage of its population. In contrast, the United States has an estimated 35.6 million people who are totally uninsured (the estimate is for 1987). Canada's health system also has broad public support, whereas recent public opinion surveys in the United States show substantial dissatisfaction with the American system of health care.[11]

Some analysts have also concluded that Canada gets greater value for its health care investment than does the U.S. In 1987, Canada spent about 8.6 percent of its GNP on health; the U.S. spent 11.2 percent. On a per capita basis, Canada spent $1,483, about 38 percent less than the U.S. total of $2,051. On almost all measures of medical care outcomes, however, such as infant death rates, life expectancy at birth, life expectancy at age 40, and age standardized death rates, Canada does better than the United States. For example, for the mid-1980s, Canada's infant mortality rate was about 25 percent lower than the U.S. rate and the average life expectancy at birth in Canada was about 72.9 years for men and 79.8 years for women compared with 71.0 and 78.3 years respectively for men and women in the U.S.

A problem in concluding that Canada is getting better value for its money is that some of the differences in medical care outcomes may not be attributable to investment in the health care system. They may have more to do with differences in rates of poverty, the demographic composition of the population, the environment, and other factors. Several foundations have begun to sponsor research that will look at whether the difference in spending between Canada and the United States has any consequences for medical care outcomes.[12]

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[11] Blendon, Robert J. Three Systems: A Comparative Survey. *Health Management Quarterly*, first quarter, 1989. p. 2-10.

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[12] Organization for Economic Cooperation and Development. *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries.* OECD Social Policy Studies No. 4, Paris, 1987.

## APPENDIX A: THE CANADIAN AND U.S. HEALTH CARE SYSTEMS: A STATISTICAL COMPARISON

The following table compares the Canadian and U.S. health care systems in terms of some common measures of health expenditures, health status indicators, and health services supply and utilization. Data are derived from the most recent available sources.

| | Canada | U.S. |
|---|---|---|
| **Health expenditures**[a] | | |
| Health expenditures as a percentage of gross domestic product, 1987 | 8.6% | 11.2% |
| Per capita health spending, 1987 | $1,483 | $2,051 |
| Public health expenditures as % of total health expenditures, 1987 | 74.8% | 41.4% |
| **Health status indicators**[b] | | |
| Infant mortality rate per 1000 live births, 1985 | 7.9 | 10.5 |
| Maternal mortality rate per 100,000 live births, 1984 | 3.2 | 8.0 |
| Life expectancy at birth, 1985 (men) | 71.9 | 71.2 |
| Life expectancy at birth, 1985 (women) | 79.0 | 78.2 |

See footnotes at end of table.

| | Canada | U.S. |
|---|---|---|
| **Hospital utilization**[c] | | |
| Short-term hospital beds per 1000 persons, 1987 | 4.4 | 3.9 |
| Average occupancy rate, 1987 | 85.5% | 64.9% |
| Average length of stay, 1987 (in days) | 14.4 | 7.2 |
| **Physician supply**[d] | | |
| Active physicians per 100,000 persons, 1980s | 187 | 194 |
| Average number of physician contacts per year, 1980s | 5.5 | 4.6 |

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[a] Schieber, George J., and Poullier, Jean-Pierre. International Health Care Expenditure Trends: 1987. *Health Affairs*, fall 1989, p. 169-177.

[b] United Nations. *United Nations Demographic Yearbook, 1986*. New York, 1988.

[c] Canada: Policy, Planning and Information Branch. Ministry of Health and Welfare. *Health Sector In Canada: Fact Sheets*. Ottawa, 1989. p. 5. United States: U.S. Library of Congress. Congressional Research Service. *Health Care Expenditures and Prices*. Issue Brief No. 77066, by Kathleen M. King. Washington, 1989. p. 10-12.

[d] Finkelstein, Alan. *Access to Health Care*. American Association of Retired People. Washington, Feb. 1989. p. 1921.

# DEBATE PROPOSITION – RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD CONTROL HEALTH CARE COSTS FOR ALL UNITED STATES CITIZENS

103d Congress, 1st Session .................... H. Doc. 103-49

**NOTICE**

*There should be no release of this document until 9 p.m., Wednesday, February 17, 1993*

# A VISION OF CHANGE FOR AMERICA

EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES
OFFICE OF MANAGEMENT AND BUDGET

February 17, 1993

THE WHITE HOUSE
WASHINGTON

February 17, 1993

*TO THE CONGRESS OF THE UNITED STATES:*

To accompany my address to the Joint Session of the Congress, I am submitting this report, entitled *A Vision of Change for America*. This report describes the comprehensive economic plan I am proposing for the nation.

I am asking you to join with the American people in their call for change. My vision is one of fundamental change—to invest in people, to reward hard work and restore fairness, and to recognize our families and communities as the cornerstones of America's strength.

For more than a decade, our government has been caught in the grip of the failed policy of trickle-down economics. While the rich get richer, middle-class Americans pay more taxes to their government and get less in return. My plan will put an end to government that benefits the privileged few and mark the beginning of an economic strategy that puts people first.

My plan has three key elements: economic stimulus to create jobs now while laying the foundation for long-term economic growth; long-term public investments to increase the productivity of our people and businesses; and a serious, fair, and balanced deficit-reduction plan to stop the government from draining the private investments that generate jobs and increase incomes.

The change will not be easy, but the cost of not changing is far greater. We must ensure that our children's generation is not the first to do worse than their parents. We must restore the American dream.

We have already heard the clamor of the powerful special interests who oppose change because they profit from the status quo. But the American people have demanded change, and it is our responsibility to answer their call. With that in mind, I ask for your help and support to restore our economy and give our people hope.

William J. Clinton

Reprinted from A Vision of Change for America, by the U.S. Executive Office of the President. Released as House Document 103-49. Washington, G.P.O., 1993. p. i, 11, 94-102, 116-145.

## Skyrocketing Health Care Costs

Another legacy of the past 12 years is the crisis of rapidly escalating health care costs—a crisis that threatens the security of every American family and business. In 1992, Americans spent $840 billion on health care, or 14 percent of GDP compared with about 9 percent of GDP only a dozen years ago (Chart 2–13). At this rate health spending will reach an astonishing 18 percent of GDP by the year 2000: Americans will be devoting almost one dollar of every five they earn to health care, and the average family's health costs will rise to almost $10,000 a year.

Rising health care costs are straining the budgets of families, businesses, and government. They are eating up incomes and squeezing out other spending. Individuals are facing soaring insurance premiums and rising out-of-pocket bills. Skyrocketing premiums have forced many businesses to drop or curtail health coverage for their workers, swelling the ranks of the uninsured. More than 37 million people do not now have insurance coverage. Many are dependent on hospital emergency units for care.

Inflation in health care costs is also robbing government budgets of scarce resources needed for critical investment in our future—education, job training, infrastructure, and technology development. If current trends continue, by 1998 the Federal Government will spend one in every four dollars on health care (Chart 2–14). State and local spending for health will rise over the same period from 14 to 18 percent of total outlays. Exploding health costs threaten funding for other public priorities.

The rise in health care costs now projected will consume between 25 and 35 percent of total projected GDP growth for the rest of the decade and will account for over 40 percent of the total increase in Federal spending. In short, containing health care costs has become an economic imperative. Indeed, the potential "health dividend" is far larger than the peace dividend promised by the end of the Cold War. If America spent the same share of GDP on health as our main international competitors do, last year alone we would have had $230 billion more to invest in our people. Similarly, if spending by employers on health insurance had remained at the 1980 percentage of total compensation, cash wages for the average worker could have been $670 a year higher in 1991 without affecting corporate profits.

Despite these bleak statistics, widespread evidence suggests that we can control health care costs and maintain quality. Other advanced industrial nations have levels of health spending substantially below ours and have controlled cost growth more successfully—even while providing care that matches and often exceeds our own. Their success offers a strong basis for hope as we step up to the challenge of fundamental change.

### *Controlling Health Care Costs*

Systemwide health care reform is a top Administration priority, but some additional short-term savings proposals, focusing on providers rather than beneficiaries, make immediate sense.

***Medicare:***

***HHS/10 percent capital reduction, inpatient.*** The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—$680 million; 1997—$380 million.

***HHS/10 percent capital reduction, OPD.*** The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—$260 million; 1997—$150 million.

***HHS/Maintain calendar year 1995 ratio of premium collections to program outlays with a 27 percent ceiling.*** Under this proposal, beginning in January, 1996, the monthly Part B premium would be set to maintain the percentage of program costs covered by premium collections in the previous year, but with a ceiling of 27 percent. The monthly Part B premium amount currently is set in law through the end of calendar year 1995 ($36.60 in CY93, $41.10 in CY94, $46.10 in CY95), and premium collections are projected to cover about 27.5 percent of program costs in 1995. When originally established, SMI premiums were intended to cover 50 percent of program costs. They eroded significantly over the years, however, and TEFRA 1982 established a temporary 25 percent premium floor, beginning in 1984. Congress extended the floor twice, and OBRA90 set fixed premium amounts in law through 1995 at levels then estimated to be approximately 25 percent of program costs. Beginning in 1996, calculation of the premium is scheduled to increase by the lower of the OASI COLA adjustment to the previous year's premium, or to be set at 50 percent of program costs. Estimated savings: over four years—$5 billion; 1997—$3.9 billion.

***HHS/Eliminate add-on payment for hospital-based HHAs.*** This proposal would eliminate the separate add-on payment that hospital-based home health agencies (HHAs) receive in addition to payment under the Medicare cost limits. Eliminating the add-on would create a level playing field on which all home health agencies can compete. Estimated savings: over four years—$840 million; 1997—$250 million.

***HHS/Eliminate skilled nursing facility return on equity payments.*** The proposal would eliminate the Medicare payment policy that pays proprietary skilled nursing facilities (SNFs) a return on equity (ROE) invested in the SNF. Medicare should pay for services rendered to beneficiaries; it should not subsidize private investment. Estimated savings: over four years—$560 million; 1997—$160 million.

***HHS/Lower IME to 5.65 percent.*** This proposal would gradually lower the Medicare indirect medical education (IME) from 7.7 percent to 5.65 percent for each .1 increase in the intern and resident to be a ratio (IRB ratio). Teaching hospitals currently receive an additional 7.7 percent payment to the Medicare DRG payment for each .1 increase in their IRB ratio, above their base year levels. The adjustment is intended to compensate these hospitals for the higher costs of delivering care incurred by inexperienced residents. In addition, teaching hospitals tend to have sicker case mixes than non-teaching hospitals. The General Accounting Office (GAO) and the Prospective Payment Assessment Commission (ProPAC) have both found that the 7.7 percent adjustment overcompensates teaching hospitals for these costs and have recommended that the adjustment be reduced. ProPAC has recommended setting the adjustment at 5.4 percent. Lowering the IME adjustment would also encourage teaching hospitals to instill within their residents more cost-effective patterns of care at an early stage in the residency. Estimated savings: over four years—$1.94 billion; 1997—$1.4 billion.

***HHS/Permanently extend 2 percent laboratory fee update.*** This proposal would extend the 2 percent annual update of Medicare reimbursement rates for clinical laboratory services. OBRA 90 established a 2 percent update through the end of 1993, after which laboratory fees would be updated by the urban component of the Consumer Price Index (CPI-U), approximately 3.5 percent annually. There is no evidence, however, to indicate that laboratory costs are increasing by the rate of inflation. Medicare payments to laboratories should more closely reflect decreasing costs due to technological advances, such as increased automation, and changes in the market, such as lower-cost equipment. Medicare payments to laboratories are already excessive. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to other, private payers. Estimated savings: over four years—$740 million; 1997—$380 million.

***HHS/Provide incentive to encourage submission of claims via electronic format.*** In total, Medicare Part B outlays were projected to be $59.8 billion in 1993. The proposal would save 0.1 percent of the 1994–98 Medicare Part B baseline. The proposal would encourage physicians and other Part B providers to submit claims via the more administratively efficient electronic format by charging physicians and other providers $1 for each paper claim filed. The proposal would not take effect until January 1, 1996, to give providers lead time to adjust their filing systems. Estimated savings: over four years—$265 million; 1997—$175 million.

***HHS/Medicare Secondary Payer (MSP) reforms.*** The MSP requirements currently vary depending upon the category of enrollee. This proposal would create a consistent MSP threshold for the aged, disabled, and end stage renal disease (ESRD) patients—all employers of 20 or more would be primary payers. Current law already requires that Medicare enrollees with employer-based health insurance use their private health insurance before drawing upon their Medicare policies. This applies more consistent standards and more efficient enforcement of these provisions to save Medicare costs. Estimated savings are $947 million for 1994 through 1997; and $305 million in 1997.

***HHS/Permanently extend reduction of payments for hospital outpatient services by 5.8 percent.*** OBRA 1990 reduced Medicare reimbursement for hospital outpatient department (OPD) reasonable costs by 5.8 percent through 1995. This proposal would extend that provision permanently. Depending on the service, OPDs are paid based upon varying formulas, some of which take into account the OPDs' reasonable costs. The overall reduction to OPDs would be much less than 5.8 percent, because less than half of Medicare reimbursement is based on reasonable costs. Because hospital inpatient reimbursement rates are constrained by DRGs, hospitals have shifted services and costs to the outpatient setting. As a result, outpatient services are one of the fastest growing components of the Medicare program, rising by an average of 17 percent per year in the 1980s. Legislators approved a 5.8 percent reduction in OBRA 1990 in an attempt to counter this rapid growth. If this provision is allowed to expire, outpatient costs, which continue to grow in the double-digits, will start growing even faster. Support for this proposal is well-established through previously approved legislation. Estimated savings are $950 million for 1994 through 1997; and $525 million in 1997.

***HHS/Reduce hospital outpatient department reimbursement by an additional 4.2 percent.*** In total, Medicare Part B outlays were projected to be $59.8 billion in 1993. The proposal would save 0.5 percent of the 1994-98 outpatient services base. Currently, Medicare reimbursement for outpatient services is based in part on the OPD's reasonable costs minus 5.8 percent, while reimbursement for outpatient capital costs is reduced by 10 percent. This proposal would reduce reimbursement for OPD services by an additional 4.2 percent beginning in 1996, to a 10 percent reduction. This would make payment for both categories consistent by reimbursing both at 90 percent of costs. Estimated savings: over four years—$690 million; 1997—$375 million.

***HHS/Ban physician self-referrals.*** A Physicians may not refer a Medicare or Medicaid patient to a clinical laboratory in which the physician or the physician's relatives have a financial interest. Several exceptions are specified in statute. This proposal would extend ownership and referral prohibitions to additional services, such as physical and occupational therapy, durable medical equipment, and parenteral/enteral nutrition equipment and supplies. Estimated savings: over four years—$250 million; 1997—$100 million.

***HHS/Set EPO at non-U.S. market rates.*** The proposal would reduce the amount Medicare pays for erythropoietin (EPO) from $11 per 1,000 units to $10 per 1,000 units. EPO is the drug used by patients suffering from kidney failure, to counter anemia by increasing the body's production of red blood cells. Medicare is virtually the sole purchaser of EPO and should exercise its market power to pay reasonable costs while maintaining access for all Medicare beneficiaries. Estimated 1997 savings are $50 million. Estimated savings 1994–1997—$160 million; savings for 1994–1998—$210 million.

***HHS/Resource-based practice expense phase-in.*** This proposal is an interim step toward a resource-based system for practice expenses. It would reduce practice expenses in relation to the relative value work units by one-half of the difference between practice expense and physician work relative value units, rent no lower than 110 percent. Phase-in to a resource-based system for practice or overvalued expenses under the physician fee schedule would begin in 1997. The recently implemented physician payment reform system divided payment into three distinct components—overhead, work, and malpractice expenses. The work component is based on an extensively-researched relative value system, developed in 1991. The existing practice expense component is based upon an obsolete fee schedule and bears no relationship to the reformed work component of the fee schedule. This proposal would only reduce the practice component in extreme instances—when it exceeds the value of the work component. More comprehensive reform of the practice component is expected to take several years to develop. This proposal provides a simple, intermediate step to address immediately the most egregious inequities in the reimbursement framework. Estimated 1997 savings—$875 million. Estimated savings 1994–1997—$2,025 million; savings for 1994–1998—$2,975 million.

***HHS/Pay hospitals for inpatient services by hospital-based physicians.*** Include payment for radiology, anesthesia, and pathology (RAP) services as an add-on to the hospital DRG payment. Separate billing by physicians for these services would not be allowed. Quality of care would be improved and unnecessary utilization would be minimized. Estimated 1997 savings are $160 million; 1994–1997—$390 million.

***HHS/Single fee for surgery.*** The fee paid to a primary surgeon would be reduced by the amount paid to assistants-at-surgery. HHS would establish exceptions by regulation in which the difficulty of the procedure or the condition of the patient necessitated the use of physicians as assistants-at-surgery. Whether assistants are used and what type of personnel are used are primarily dependent on geographic practice patterns and the practice styles of individual surgeons, rather than on characteristics related to the specific patient and the surgery performed. Evidence does not show that quality of care would be jeopardized. Estimated 1997 savings is $120 million; 1994–1997—$380 million.

***HHS/Durable Medical Equipment (DME) options—Set DME at market levels.*** Initially, fee schedules for DME would be adjusted downward with an upper limit based upon the median DME fee schedule, rather than the national average. The fee schedule for prosthetics and orthotics would also be recomputed with a national median cap. The HHS Secretary would be authorized to adjust DME rates based upon market factors, including surveys of what other providers, such as the VA, DoD and the private sector, pay for DME. The Secretary also would be authorized to initiate competitive bidding programs for DME supplies where appropriate. Granting broader HHS discretion would allow adjustments to be made to reflect changes in technology, utilization patterns and other market factors. Estimated savings are $510 million for 1994–97; and $160 million in 1997.

***HHS/Direct medical education.*** This proposal would base Medicare direct medical education payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighing of the national average resident salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident salary, down from the average weight of about 215 percent under current law. Estimated savings: over four years—$1.4 billion; 1997—$330 million.

***HHS/Set laboratory rates at market levels.*** The proposal initially would limit the Medicare Part B laboratory fee schedule to 76 percent of the median of all fees (as opposed to current maximum of 88 percent). Later, based on market surveys, the Secretary of HHS would adjust Medicare payment rates to laboratories to account for technological changes or other market factors. This proposal would address excessive Medicare payments for laboratory tests. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to private payers. In addition, the proposal would control growth in Medicare Part B laboratory payments, which more than doubled from 1985 to 1990. Estimated savings: over four years—$3.1 billion; 1997—$1.1 billion.

***HHS/Reduce default Medicare volume performance standard and update.*** The effect of this proposal is to reduce the amount of increases in physician fees in future years. This proposal would reduce the Medicare volume performance standard (MVPS) default formula and the default update for Medicare payments to physicians. These two factors determine annual aggregate physician payment levels. Estimated savings: over four years—$850 million; 1997—$650 million.

***HHS/Permanently extend three current Medicare Secondary Payer (MSP) provisions.*** The proposal would extend three OBRA '90 Medicare Secondary Payer provisions due to expire at the end of 1995 including: (1) 1862(b) of the Social Security Act authorizing MSP for disabled active individuals with employer group health plan (EGHP) coverage; (2) 1826(c) of the Social Security Act amended by OBRA '90 authorizing MSP for individuals with ESRD after 18 months (expanded from 12 months); and (3) 8051 of OBRA '90 authorizing an IRS/SSA data match for MSP. The data match authorizes access to tax data to identify the existence of EGHP for MSP purposes. Estimated savings over four years—$1.845 billion; 1997 savings—$1.115 billion.

***HHS/Put hospitals on calendar year update.*** Medicare payments to hospitals for inpatient care are updated October 1 of each year. Most other Medicare services are updated January 1 or July 1. This proposal would move the hospital update to January 1. Estimated savings: over four years—$4.6 billion; 1997 $1.3 billion.

***HHS/Fully increase primary care fees; modestly increase doctor fees in 1994.*** The proposal would update in full the physician fee schedule in CY 1994 for primary care services only. For all other physician services, the update would be two percentage points less than the full update. Estimated savings: over four years—$1.3 billion; in 1997—$400 million.

***HHS/Reduce Medicare hospital update market basket by 1 percent in 1994 and 1 percent in 1995.*** This proposal would extend the current law practice of PPS updates of less than the hospital market basket index (HMBI). The 1993 update of the PPS standardized amount is set at the HMBI minus 1.55 percent for urban hospitals and HMBI minus 0.55 percent for rural hospitals, as set in OBRA 1990. Under current law, the update for urban hospitals will equal the market basket rate of increase in 1994 and 1995. For rural hospitals the update is set at market basket plus 1.5 percent for 1994 and the HMBI plus an adjustment needed to match the urban rate in 1995. Estimated savings: over four years—$5.19 billion; 1997—$1.7 billion.

***HHS and others: Third party liability—enhanced identification of other health coverage.*** Federal and State taxpayers spend over $1.5 billion a year for health care that should be paid for by others. Inappropriate payments have been identified in most federally-assisted or financed health programs including: Medicare, Medicaid, Veterans Affairs Health, CHAMPUS/DOD Direct Care, and the Indian Health Service. This proposal removes many of the structural impediments hindering proper identification and billing of third party liability (TPL) by: (1) requiring employers to report employment based health coverage data annually on the W-2; (2) granting access to this data to all federally-assisted and financed health programs; (3) reinforcing existing coordination of benefits (which payer pays and in what order) laws and regulations; and (4) removing impediments that hinder states from collecting from private insurers. Rather than the current 'pay and chase' procedures where federal programs pay first and chase payers afterwards, this proposal focusses on avoiding erroneous payments by identifying the appropriate coverage **before** payment.

***Medicaid:***

***HHS/Tighten estate recovery/transfer of assets rules.*** Total Federal Medicaid outlays for 1993 are projected to be $80.3 billion. This proposal would save approximately 0.1 percent of the 1994–98 Medicaid baseline. This proposal would strengthen transfer-of-asset rules to restrict further the diverting of property to qualify for Medicaid. In addition, the Federal government would require States to operate estate recovery programs and would enhance States' abilities to implement these programs. Estimated savings: over four years—$395 million; 1997—$155 million.

***HHS/Remove prohibition on State use of drug formularies.*** This proposal would repeal the OBRA 1990 statutory provisions that prohibit States from using formularies. Before OBRA 1990, States were allowed to limit the number of drugs listed on their formularies, e.g., States could cover only the generic alternative of a multiple-source drug. The OBRA 1990 formulary restriction resulted in increased expenditures for States and the Federal government. Estimated savings: over four years—$70 million; 1997—$25 million.

***HHS/Eliminate mandatory Medicaid personal care.*** This proposal would ensure that personal care remains an optional benefit after 1994. The Medicaid statute requires States to cover home health services for all individuals who are eligible for nursing home services. Currently, States also have the option to pay for personal care services to these individuals. Due to a legislative drafting error, OBRA-90 designated personal care as a home health service. Therefore, coverage of personal care services would become mandatory for all States in 1995, if Congress does not amend the statute. In an era of increasing fiscal pressures and growing Medicaid spending, Congress should avoid imposing additional mandates upon State Medicaid programs. Moreover, maintaining personal care as an optional service would allow States continued flexibility in designing and administering Medicaid long-term care strategies. Estimated savings: for four years—$4.1 billion; 1997—$1.5 billion.

### *Shared Contribution*

For deficit reduction to succeed, all groups must contribute. Only if there is a sharing of the load can the entire country be sure that everyone is participating.

***Social Security/Conform taxation of benefits to private pensions.*** Up to 50 percent of Social Security and Railroad Retirement (Tier I) benefits are currently included in taxable income for those recipients with income and benefits exceeding $25,000 for individuals, and $32,000 for couples. The Administration proposes including up to 85 percent of benefits in adjusted gross income, for those with income and benefits exceeding the current $25,000/$32,000 thresholds. This would move the treatment of Social Security and Railroad Retirement Tier I benefits toward that of private pensions. Under current law, pension benefits that exceed an employee's after-tax contributions to qualified pension plans are subject to tax at distribution. Extending this approach to Social Security would mean including at least 85 percent of benefits in taxable income for nearly all recipients. However, maintaining the existing income thresholds protects most low- and middle-income beneficiaries from benefit taxation.

***HHS/Strengthening child support enforcement.*** Of the over 10 million women living alone with their children, only half have child support orders and only half of those women receive full payment. Child support enforcement will be strengthened by streamlining paternity establishment; using the IRS to collect seriously delinquent child support; making sure that absent parents who can pay child support do; setting up a national registry to track down deadbeat parents; requiring employees to report child support obligations on IRS W-4 forms; and improving medical support for children. Better child support enforcement will ensure both parents' responsibility for the well being of their children and decrease the burden of welfare on the taxpayer. Estimated Savings: over four years—$328 million; 1997—$109 million..

***HHS/Equate matching rates for welfare programs.*** Currently, States are reimbursed by the Federal Government at different rates for the various costs of administering Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid. The Administration proposes to set the Federal reimbursement rate at a uniform 50 percent for all administrative costs of each of these three programs. There will be waivers for some States, in hardship cases. Estimated savings: over four years—$1.8 billion; 1997—$600 million.

***OPM/End lump-sum benefit retirement.*** The lump-sum retirement option allows Federal civilian employees to elect upon retirement to receive a lump sum roughly equal to employee contributions in exchange for a reduced annuity for life. The Omnibus Budget Reconciliation Act suspended the lump sum for 5 years, through 1995, for all employees except those who are critically ill, involuntarily separated or activated for Desert Shield/Storm. This proposal would eliminate the lump sum for all employees retiring on or after October 1, 1995. Estimated 1994–97 savings: $5.1 billion. Estimated 1997 savings: $3 billion.

***Veterans Affairs/Permanently extend medical care cost recovery.*** The VA operates a nationwide health care delivery system for our nation's veterans. This proposal would make permanent VA's authority to collect the cost of medical care from health insurers of veterans with service-connected (military related) disabilities when the care is provided for non-service-connected conditions. This proposal would hold private health insurance companies responsible for the costs of their beneficiaries' care. VA already has permanent authorization to collect costs from insurers of veterans without service-connected conditions. Estimated savings: over four years—$1.2 billion; 1997—$407 million.

***Veterans Affairs/Permanently extend prescription charge/copayment.*** The VA operates a nationwide health care delivery system for our nation's veterans. This proposal would make permanent VA's authority to collect from most veterans a $2 copayment for each 30-day supply of outpatient prescription drugs that is not related to treatment of a service-connected (military related) disability. Cost sharing encourages more appropriate utilization of prescription drugs. This proposal has been enacted three times by the Congress (currently through 1997). Estimated savings in 1998—$42 million.

## The Role of Health Care Costs

Even the most favorable scenarios for economic growth under our plan leave unfinished business, however. The budget totals conceal rapidly rising health care spending that threatens to bankrupt our national treasury.

Recently, health care costs have accounted for almost half of the increase in Federal spending; if we do nothing, by decade's end one in every four Federal dollars will go to providing health care. Relentlessly rising costs will continue to stunt long-term economic growth—and terrorize American families—unless and until we achieve fundamental change.

Later this spring we will deliver to the Congress a comprehensive plan for change. That plan will control health care costs and will provide security to families, so that they cannot be denied the coverage they need. It will root out fraud and outrageous charges, and make sure that paperwork no longer chokes consumers or doctors. And it will maintain American standards—the highest quality medical care in the world, and the choices we all deserve.

Our health care plan will bring costs under control. And while the savings we achieve will go mostly to the private sector, taxpayers will benefit as well. Federal funds will be freed for investments in education, training, and the technologies of tomorrow.

That reform will control the growth of Medicare and Medicaid spending in the long term, and thereby supplement the deficit reduction in this economic program. If the growth of Federal health care costs can be limited to the rate of growth of the population, plus the rate of inflation, plus two percent, the deficit will decline in dollar terms and as a percentage of the GDP (Charts 4–1 and 4–2); and the increase in the ratio of the national debt to the GDP of the 1980s will be reversed (Chart 4–3).

Enactment of the economic plan and health care reform together will reverse the failures of the 1980s, and put the economy on a sound footing for the next century. It will reduce the threat of financial instability posed by a national debt rising faster than our income. It will stop sending the signal to the rest of the industrialized world that our economic policy is out of control. Most important, it will add to the prosperity and security of the American people and allow us to compete more effectively in the global economy.

## Conclusion: A Vision of Change for America

Throughout our history, at every critical moment, Americans have summoned the courage to change, to adapt our nation's policies and institutions to changing problems and a changing world. Once again we face such a challenge. Now we must change our course.

We need a change to restore what makes America great: a vision of economic and political freedom; of the rewards of hard work and initiative; of a fundamental sense of fairness, of our families and our communities as foundations of our strength; and of every generation's obligation to create a better life for those that follow.

The plan we present invests in our people and promises an America where a growing economy produces rising living standards and high-wage, high-skill jobs. It rewards hard work and restores fairness, providing opportunity in return for responsibility. It ends twelve years of government that served only the privileged and returns that government to its rightful owners: the American people.

Here in Washington, the powerful special interests are already doing their best to suffocate change. They oppose it because they profit from the status quo. They refuse to listen to the American people's call for change.

It is our responsibility to answer that call and restore hope to our people. The voices of conventional wisdom will first whisper and then shout that it cannot be done. But we must summon the wisdom and courage to reject convention and embrace the new direction that we have needed for so long.

Chart 4-1. FEDERAL DEFICIT PROJECTIONS 1993 - 2003

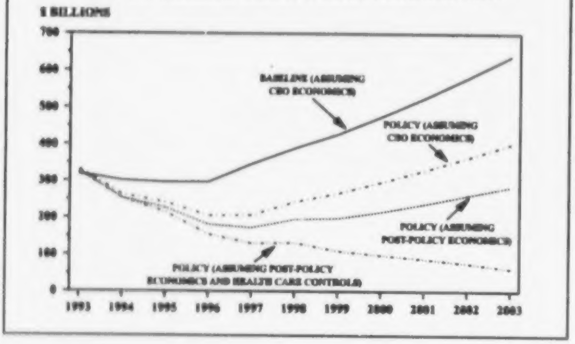

Chart 4-2. FEDERAL DEFICIT PROJECTIONS 1993 - 2003
(as a percent of GDP)

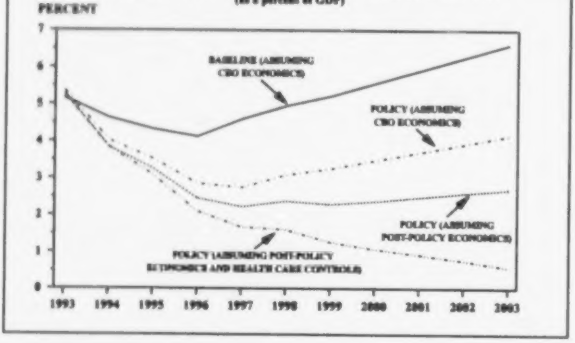

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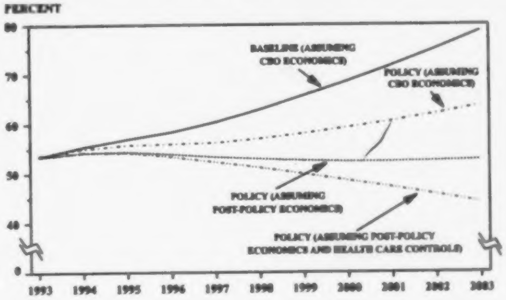
Chart 4-3. FEDERAL DEBT PROJECTIONS 1993 - 2003
(as a percent of GDP)



# Appendix

TABLE 1. DEFENSE DISCRETIONARY PROPOSALS

(In billions of dollars)

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|---|
| Current OBRA Baseline: | | | | | | |
| Budget Authority | 274.3 | 288.0 | 296.4 | 304.5 | 312.9 | 321.5 |
| Outlays | 294.3 | 289.6 | 293.8 | 299.8 | 306.5 | 313.8 |
| Change from OBRA to Bush Adjusted: | | | | | | |
| Budget Authority | ........ | -12.5 | -18.4 | -26.2 | -28.3 | -28.1 |
| Outlays | ........ | -5.3 | -9.5 | -15.2 | -20.0 | -24.8 |
| Current Bush Adjusted Baseline: | | | | | | |
| Budget Authority | ........ | 275.5 | 278.0 | 278.3 | 284.6 | 293.4 |
| Outlays | ........ | 284.4 | 284.3 | 284.6 | 286.5 | 289.0 |
| Proposed Policy Changes: | | | | | | |
| Budget Authority | ........ | -11.8 | -15.2 | -24.5 | -36.2 | -39.2 |
| Outlays | ........ | -6.7 | -11.7 | -19.7 | -37.4 | -36.3 |
| Proposed Defense Discretionary: | | | | | | |
| Budget Authority | 274.3 | 263.7 | 262.8 | 253.8 | 248.4 | 254.2 |
| Outlays | 294.3 | 277.7 | 272.6 | 264.9 | 249.1 | 252.7 |

## TABLE 2. NON-DEFENSE DISCRETIONARY PROGRAM SAVINGS

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| **PROGRAMS THAT DON'T WORK OR ARE NO LONGER NEEDED** | | | | | | |
| Commerce: | | | | | | |
| Eliminate Trade Adjustment Assistance for firms | -1 | -5 | -10 | -14 | -14 | -30 |
| Reduction in Export Administration workload | -6 | -7 | -7 | -7 | -7 | -27 |
| Health and Human Services: | | | | | | |
| Fund priority health professions curriculum assistance grants | -14 | -21 | -25 | -27 | -29 | -87 |
| State: | | | | | | |
| Eliminate Russia/Eurasia research | -1 | -8 | -10 | -10 | -11 | -29 |
| Environmental Protection Agency: | | | | | | |
| Completion of wastewater treatment grants authorization (except NAFTA) | -109 | -624 | -1,424 | -1,947 | -2,207 | -4,104 |
| Appalachian Regional Commission: | | | | | | |
| Freeze Appalachian Regional Commission | -1 | -2 | -6 | -11 | -12 | -20 |
| Community Investment Program: | | | | | | |
| Reforms in light of new crime initiative | | -211 | -411 | -532 | -560 | -1,154 |
| State Justice Institute: | | | | | | |
| Terminate State Justice Institute | -3 | -15 | -16 | -17 | -17 | -51 |
| Tennessee Valley Authority: | | | | | | |
| Terminate TVA fertilizer and community development | -42 | -46 | -50 | -50 | -52 | -188 |
| Multi-Agency: | | | | | | |
| Eliminate unnecessary nuclear reactor R&D | -87 | -198 | -257 | -278 | -279 | -820 |
| Terminate commissions | -9 | -10 | -11 | -11 | -11 | -41 |
| Subtotal, Programs That Don't Work or are No Longer Needed | -273 | -1,147 | -2,227 | -2,904 | -3,199 | -6,551 |
| **ELIMINATING SUBSIDIES: CHARGING FEES FOR GOVERNMENT SERVICES** | | | | | | |
| Agriculture: | | | | | | |
| Reduce Rural Electrification Administration 5-percent loan subsidies | -27 | -77 | -120 | -150 | -171 | -374 |
| Expand certain agriculture user fees | -14 | -14 | -15 | -16 | -16 | -59 |
| Eliminate Cooperative State Research Service (CSRS) earmarked research grants | -4 | -18 | -32 | -42 | -46 | -96 |
| Eliminate CSRS earmarked facilities construction | -3 | -7 | -32 | -44 | -60 | -86 |
| Eliminate earmarked special extension grants | -13 | -13 | -14 | -14 | -15 | -54 |
| Eliminate Agricultural Research Service earmarked facilities construction | -1 | -6 | -7 | -10 | -10 | -24 |
| Meat/Poultry fees: Reimbursement for overtime | -104 | -104 | -104 | -104 | -104 | -416 |
| Commerce: | | | | | | |
| Terminate NOAA demonstration projects | -30 | -55 | -65 | -70 | -73 | -220 |
| Corps of Engineers: | | | | | | |
| Reduce construction funding for lower priority water projects | -65 | -70 | -30 | -60 | -15 | -225 |
| Energy: | | | | | | |
| Assess foreign customers decommissioning and decontamination fee (receipts) | -10 | -10 | -11 | -11 | -12 | -42 |
| Health and Human Services: | | | | | | |
| Increase FDA user fees | -167 | -230 | -295 | -326 | -367 | -1,018 |

## TABLE 2. NON-DEFENSE DISCRETIONARY PROGRAM SAVINGS–Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Housing and Urban Development: | | | | | | |
| Eliminate special purpose grants | -5 | -73 | -209 | -278 | -288 | -565 |
| Interior: | | | | | | |
| Reduce construction funding for lower priority water projects | -18 | -40 | -63 | -42 | -23 | -163 |
| Transportation: | | | | | | |
| Eliminate low priority Transportation programs and projects | -129 | -337 | -438 | -428 | -417 | -1,332 |
| Treasury: | | | | | | |
| Establish a Bureau of Alcohol, Tobacco, and Firearms user fee | -5 | -5 | -5 | -5 | -5 | -20 |
| Small Business Administration: | | | | | | |
| Eliminate SBA earmarked grants | -44 | -71 | -90 | -110 | -116 | -315 |
| Securities and Exchange Commission: | | | | | | |
| Increase SEC Registration Fees | -47 | -50 | -52 | -54 | -56 | -203 |
| **Subtotal, Eliminating Subsidies: Charging Fees for Government Services** | -706 | -1,180 | -1,572 | -1,764 | -1,814 | -5,222 |
| **MANAGING GOVERNMENT FOR COST-EFFECTIVENESS AND RESULTS** | | | | | | |
| Agriculture: | | | | | | |
| Reduce Enterprise for the Americas debt forgiveness (P.L. 480) | -6 | -17 | -20 | -36 | -38 | -79 |
| Reduce development-oriented foreign food aid | -30 | -63 | -72 | -81 | -90 | -246 |
| Phase out below-cost timber sales (Forest Service) | -46 | -59 | -83 | -86 | -86 | -274 |
| Implement one new Farm Service Organization | -65 | -139 | -219 | -307 | -403 | -730 |
| Reform crop insurance through area-yield | -105 | -110 | -165 | -171 | -177 | -551 |
| Reduce Economic Research Service programs | -12 | -16 | -16 | -17 | -18 | -61 |
| Reduce Foreign Agriculture Service programs | -5 | -10 | -10 | -10 | -10 | -35 |
| Reduce direct ACIF farm loans 25%; replace with guarantees | -3 | -8 | -10 | -10 | -11 | -31 |
| Education: | | | | | | |
| Reform campus-based aid | -20 | -198 | -239 | -275 | -312 | -732 |
| Phase out impact aid "b" | -39 | -86 | -134 | -145 | -149 | -404 |
| Energy: | | | | | | |
| Stretchout Superconducting Super Collider | 108 | | | | | 108 |
| Implement uranium enrichment initiative | -241 | -274 | -374 | -386 | -340 | -1,275 |
| Reduce Strategic Petroleum Reserve fill by one-third | -55 | -58 | -22 | 37 | 39 | -98 |
| Housing and Urban Development: | | | | | | |
| Eliminate public housing new construction amendments | | | -7 | -36 | -58 | -43 |
| Modify fees Federal housing | -40 | -85 | -136 | -193 | -204 | -454 |
| Reforming low-income housing preservation | -5 | -15 | -37 | -58 | -80 | -115 |
| Consolidate several HUD housing programs into HOME | -1 | 29 | -56 | -150 | -474 | -178 |
| Justice: | | | | | | |
| Reduce prison construction | -7 | -40 | -103 | -181 | -249 | -331 |
| Transportation: | | | | | | |
| Maintain level Federal Aviation Administration (Operations) | -55 | -62 | -62 | -62 | -62 | -241 |
| Adjust Coast Guard for military pay | -29 | -53 | -69 | -86 | -99 | -237 |
| Veterans Affairs: | | | | | | |
| Reform major construction | -7 | -46 | -95 | -134 | -152 | -282 |
| Improve management of VA hospitals | -100 | -200 | -300 | -400 | -500 | -1,000 |

## TABLE 2. NON-DEFENSE DISCRETIONARY PROGRAM SAVINGS—Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Environmental Protection Agency: | | | | | | |
| Increase private sector Superfund financing | -31 | -73 | -95 | -109 | -118 | -308 |
| National Aeronautics and Space Administration: | | | | | | |
| Redesign Space Station and invest in new technology | 203 | 682 | 625 | 636 | 510 | 2,136 |
| Small Business Administration: | | | | | | |
| Reduce 7(a) business loan subsidies | -59 | -113 | -116 | -118 | -121 | -406 |
| Board for International Broadcasting: | | | | | | |
| Consolidate overseas broadcasting | -60 | -59 | -281 | -244 | -250 | -644 |
| Executive Office of the President: | | | | | | |
| Cut White House and Office of National Drug Control Policy staff | -20 | -32 | -37 | -40 | -43 | -129 |
| Funds Appropriated to the President: | | | | | | |
| Re-orient AID programs and reduce spending | -7 | -84 | -152 | -257 | -341 | -500 |
| Phase out defense acquisition fund | -23 | -92 | -138 | -133 | -86 | -386 |
| Reduce International Security Assistance | -64 | -204 | -504 | -731 | -943 | -1,503 |
| Reduce Enterprise for the Americas debt forgiveness (AID) | -8 | -20 | -34 | -45 | -54 | -107 |
| Export Import Bank of the United States: | | | | | | |
| Reduce Export Import Bank credits | -3 | -6 | -39 | -105 | -148 | -153 |
| U.S. Information Agency: | | | | | | |
| Russian Far East Technical Assistance Center | -2 | -2 | -2 | -2 | -2 | -8 |
| Terminate funding for North-South Center | -4 | -9 | -9 | -10 | -10 | -32 |
| Multi-Agency: | | | | | | |
| Freeze other foreign assistance programs | -6 | -14 | -75 | -95 | -111 | -190 |
| Maintain current program level for programs in small agencies | -12 | -30 | -60 | -92 | -124 | -194 |
| No Federal Pay Raise CY94; ECI-Based Raise minus 1% CY1995–1997; revise locality pay beginning CY1995 | -1,361 | -1,963 | -2,281 | -2,741 | -2,965 | -8,346 |
| Administrative Efficiencies: | | | | | | |
| Cut 100,000 Federal employees | -932 | -2,180 | -2,306 | -2,509 | -2,591 | -7,927 |
| Other administrative savings | -676 | -1,392 | -2,169 | -3,462 | -3,553 | -7,699 |
| Reduce overhead rate on university R&D | -156 | -330 | -369 | -383 | -396 | -1,238 |
| Subtotal, Managing Government for Cost-Effectiveness and Results | -4,003 | -7,511 | -10,271 | -13,227 | -14,819 | -35,012 |
| **STREAMLINING GOVERNMENT** | | | | | | |
| Agriculture | -38 | -76 | -96 | -117 | -139 | -327 |
| Education | -70 | -318 | -486 | -620 | -758 | -1,494 |
| Energy | | -1 | -3 | -7 | -12 | -11 |
| Health and Human Services | -199 | -500 | -832 | -1,168 | -1,512 | -2,699 |
| Housing and Urban Development | -104 | -265 | -443 | -621 | -822 | -1,433 |
| Justice | -25 | -19 | -38 | -56 | -73 | -138 |
| Labor | -2 | -52 | -105 | -161 | -215 | -320 |
| Transportation | -10 | -25 | -33 | -44 | -54 | -112 |
| Treasury | -33 | -52 | -63 | -68 | -73 | -216 |
| Veterans Affairs | | -1 | -3 | -6 | -10 | -10 |
| Corps of Engineers | -13 | -34 | -56 | -77 | -99 | -180 |
| Environmental Protection Agency | -10 | -38 | -70 | -103 | -137 | -221 |
| Other agencies | -100 | -170 | -230 | -267 | -292 | -767 |
| Subtotal, Streamlining Government | -604 | -1551 | -2,456 | -3,315 | -4,196 | -7,926 |

## TABLE 2. NON-DEFENSE DISCRETIONARY PROGRAM SAVINGS–Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| TECHNICAL ADJUSTMENTS | | | | | | |
| Agriculture | -9 | -10 | -10 | -10 | -11 | -39 |
| Commerce | -30 | -11 | 5 | 53 | 257 | 17 |
| Education | 66 | 122 | 131 | 135 | 134 | 454 |
| Energy | 214 | ............ | ............ | -35 | -144 | 179 |
| Health and Human Services | -105 | -91 | -74 | -61 | -48 | -331 |
| Interior: | | | | | | |
| Indian Land and Water Rights Claim Settlements | 200 | 200 | 200 | 200 | 200 | 800 |
| Other Interior programs | 2 | 0 | -4 | -8 | -10 | -10 |
| Justice | 41 | 55 | 65 | 72 | 78 | 233 |
| Labor: | | | | | | |
| Unemployment Insurance administration workload adjustment | 130 | 133 | 126 | 119 | 143 | 508 |
| Other Labor programs | -54 | -194 | -265 | -270 | -281 | -783 |
| State | 169 | 106 | 147 | 79 | 117 | 501 |
| Transportation | 104 | 122 | 127 | 135 | 144 | 488 |
| Treasury: | | | | | | |
| United States Customs | 29 | 29 | 30 | 31 | 32 | 119 |
| Fund additional IRS tax compliance efforts | 143 | 156 | 163 | 171 | 178 | 633 |
| Environmental Protection Agency | -15 | -59 | -95 | -102 | -104 | -271 |
| General Services Administration | -89 | -90 | -96 | -222 | -323 | -497 |
| Office of Personnel Management | 3 | 9 | 8 | 5 | 9 | 25 |
| Funds Appropriated to the President: International Affairs programs | 236 | 469 | 533 | 580 | 540 | 1,818 |
| Other agencies | 83 | 250 | 131 | 110 | 97 | 574 |
| Subtotal, Technical Adjustments | 1,118 | 1,196 | 1,122 | 982 | 1,008 | 4,418 |
| TOTAL, all categories | -4,478 | -10,193 | -15,408 | -20,218 | -23,010 | -50,296 |

## TABLE 3. PROPOSED CHANGES TO MANDATORY PROGRAMS

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| **ELIMINATING SUBSIDIES: CHARGING FEES FOR GOVERNMENT SERVICES** | | | | | | |
| Energy: | | | | | | |
| Reform Power Marketing Administration | | | -100 | -100 | -100 | -200 |
| Natural Resources and Environment: | | | | | | |
| Phase-in increased Inland Waterway user fees | -35 | -115 | -210 | -460 | -480 | -820 |
| Increase grazing fees: Agriculture Department | -2 | -5 | -8 | -13 | -19 | -28 |
| Increase grazing fees: Interior Department | -4 | -8 | -14 | -22 | -32 | -48 |
| Implement a Federal irrigation water surcharge | -10 | -10 | -10 | -15 | -15 | -45 |
| Increase recreation fees: Corps of Engineers | -18 | -18 | -18 | -18 | -18 | -72 |
| Increase recreation fees: Interior Department | -29 | -34 | -39 | -45 | -50 | -147 |
| Increase recreation fees: Agriculture Department | -10 | -11 | -12 | -13 | -13 | -46 |
| Permanently extend hardrock mining holding fees | -80 | -80 | -80 | -80 | -80 | -320 |
| Institute hardrock mining royalties | | -63 | -131 | -277 | -277 | -471 |
| Improve enforcement of harbor maintenance fees | -10 | -25 | -65 | -65 | -65 | -165 |
| Permanently extend 50% net receipt sharing (on-shore minerals) | -40 | -42 | -43 | -45 | -47 | -170 |
| Below-cost timber sales (loss of receipts) | 38 | 48 | 58 | 58 | 58 | 202 |
| Agriculture: | | | | | | |
| Eliminate subsidies to honey producers | -12 | -10 | -6 | -4 | -3 | -32 |
| Target CCC subsidies to farmers with off-farm incomes below $100,000 | -75 | -115 | -140 | -140 | -140 | -470 |
| Increase non-eligible payment acres (triple base) starting in 1996 | | | -310 | -720 | -720 | -1,030 |
| Eliminate 0/92 and 50/92 (PAY/92) programs starting in 1996 | | | -273 | -664 | -640 | -937 |
| Increase assessments on "non-program" crops starting in 1996 | | | -450 | -450 | -450 | -900 |
| Limit payments on wool and mohair to $50 thousand per person | -10 | -66 | -68 | -68 | -68 | -212 |
| Permanently extend market promotion program at 1993 level | -52 | -52 | -52 | -52 | -52 | -208 |
| Commerce and Housing Credit: | | | | | | |
| Assess examination fees for State-chartered, FDIC-insured banks | -256 | -265 | -275 | -285 | -297 | -1,081 |
| Institute Commodity Futures Trading Commission processing fees (revenue) | -55 | -57 | -60 | -63 | -66 | -235 |
| Increase Securities and Exchange Commission registration fees (revenue) | -44 | -46 | -48 | -50 | -52 | -188 |
| Permanently extend patent and trademark fees | | | -111 | -115 | -120 | -226 |
| Transportation: | | | | | | |
| Increase registration fee on general aviation aircraft | -18 | -31 | -44 | -58 | -60 | -151 |
| Permanently extend tonnage fees | | | -67 | -68 | -70 | -135 |
| Health: | | | | | | |
| Complete payment of outstanding postal liabilities: FEHB portion | | -116 | -116 | -116 | | -348 |
| Income Security: | | | | | | |
| Charge fee for State SSI administration | -50 | -110 | -180 | -180 | -180 | -520 |

## TABLE 3. PROPOSED CHANGES TO MANDATORY PROGRAMS–Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Administration of Justice: | | | | | | |
| Permanently extend U.S. Customs merchandise and passenger processing fees | | | -564 | -579 | -607 | -1,143 |
| Undistributed Offsetting Receipts: | | | | | | |
| Auction Federal Communications Commission spectrum | | -374 | -1,623 | -2,083 | -340 | -4,080 |
| Complete payment of outstanding postal liabilities: Cost-of-living adjustments for retirees | | -231 | -231 | -231 | | -693 |
| **Subtotal, Eliminating Subsidies: Charging fees for Government Services** | -771 | -1,838 | -5,290 | -7,020 | -4,981 | -14,919 |
| **MANAGING GOVERNMENT FOR COST-EFFECTIVENESS AND RESULTS** | | | | | | |
| Agriculture: | | | | | | |
| Reform crop insurance program through area-yield (mandatory savings) | | -238 | -246 | -255 | -264 | -739 |
| Reform commodity disaster payments | | | | | | |
| Commerce and Housing Credit: | | | | | | |
| Government National Mortgage Association: Real estate mortgage insurance conduits | -146 | -146 | -146 | -146 | -146 | -584 |
| Reform Federal Housing Administration insurance | -28 | -66 | -78 | -81 | -83 | -253 |
| Education, Training, Employment, and Social Services: | | | | | | |
| Reform student loan program | 171 | 213 | -378 | -1,343 | -1,833 | -1,337 |
| Require States to share default costs | -88 | -122 | -128 | -131 | -137 | -469 |
| Income Security: | | | | | | |
| Conform CSRS/FERS child-survivor benefits age to Social Security | -5 | -10 | -15 | -20 | -25 | -50 |
| Base CSRS/FERS survivor annuities on reduced retiree annuity | -35 | -70 | -105 | -140 | -175 | -350 |
| Veterans Benefits and Services: | | | | | | |
| Restore 1:9 contribution ratio for GI Bill benefits | -88 | -83 | -80 | -88 | -108 | -339 |
| Implement housing down-payment for second and subsequent uses | -17 | -17 | -17 | -17 | -17 | -68 |
| Pay insurance administration from excess funds | -25 | -28 | -29 | -31 | -32 | -113 |
| Set housing loan fees at 2% | -153 | -155 | -155 | -157 | -166 | -620 |
| Permanently extend pensions-medicaid nursing homes provisions | | | | | -300 | |
| Permanently extend pension/medical care income verification through Internal Revenue Service | | | | | -197 | |
| Permanently extend medical care costs recovery | -46 | -326 | -391 | -407 | -425 | -1,170 |
| Permanently extend prescription charge/co-payment | | | | | -42 | |
| Permanently extend resale loan loss provisions | -19 | -20 | -20 | -21 | -22 | -80 |
| Administration of Justice: | | | | | | |
| Reform U.S. Customs overtime | -18 | -18 | -18 | -18 | -18 | -72 |
| General Government: | | | | | | |
| Implement Commonwealth of the Northern Mariana Islands funding agreement | -6 | -7 | -8 | -10 | -12 | -31 |
| Net Interest: | | | | | | |
| Shorten maturity of debt securities | -1,294 | -2,880 | -3,384 | -3,919 | -4,877 | -11,477 |

## TABLE 3. PROPOSED CHANGES TO MANDATORY PROGRAMS—Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Other: | | | | | | |
| FTE cut—offsets—employer contributions | 115 | 269 | 284 | 310 | 320 | 978 |
| FTE cut—offsets—employee contributions | 29 | 67 | 71 | 77 | 80 | 244 |
| Pay reduction—related employee contributions | 71 | 95 | 109 | 131 | 141 | 406 |
| Increase revenues from IRS tax compliance efforts | -11 | -74 | -297 | -554 | -601 | -936 |
| **Subtotal, Managing Government for Cost-effectiveness and results** | -1,905 | -3,396 | -4,919 | -6,830 | -8,938 | -17,050 |
| CONTROLLING HEALTH CARE COSTS | | | | | | |
| Health: | | | | | | |
| Institute Medicare fee limits over 65: Federal Employees Health Benefits | -12 | -18 | -21 | -24 | -27 | -75 |
| Medicaid: Eliminate mandatory medicaid care | | -1,190 | -1,365 | -1,540 | -1,760 | -4,095 |
| Medicaid: Tighten estate asset rules | -25 | -80 | -135 | -155 | -170 | -395 |
| Medicaid: Remove prohibition on drug formularies | -10 | -15 | -20 | -25 | -30 | -70 |
| Medicare: | | | | | | |
| Pay hospitals for inpatient services by hospital-based physicians | | -80 | -150 | -160 | -180 | -390 |
| Put hospitals on a calendar year update | -1,000 | -1,140 | -1,180 | -1,290 | -1,420 | -4,610 |
| Gradually lower indirect medical education rate to 5.65% | | | -580 | -1,360 | -1,800 | -1,940 |
| Set laboratory rates at market levels | -380 | -680 | -890 | -1,130 | -1,380 | -3,080 |
| Eliminate skilled nursing facility return on equity payments | -110 | -140 | -150 | -160 | -170 | -560 |
| Durable medical equipment—options | -75 | -125 | -150 | -160 | -175 | -510 |
| Set erythropoietin (EPO) at non-U.S. market rates ($10 per 1000 units) | -30 | -40 | -40 | -50 | -50 | -160 |
| Medicare secondary payor (MSP) reforms | -127 | -240 | -275 | -305 | -345 | -947 |
| Eliminate add-on for hospital based home health agency | -160 | -200 | -230 | -250 | -280 | -840 |
| Phase-in resource-based practice expense | -100 | -350 | -700 | -875 | -950 | -2,025 |
| Implement single fee for surgery | -60 | -100 | -110 | -120 | -130 | -390 |
| Discount for interactions | 160 | 200 | 480 | 940 | 1,410 | 1,780 |
| Reduce hospital update market basket minus 1% in 1994 and 1995 | -550 | -1,380 | -1,560 | -1,700 | -1,880 | -5,190 |
| Permanently extend 10% capital reduction, outpatient department | | | -110 | -150 | -170 | -260 |
| Permanently extend 2% laboratory fee update | -30 | -110 | -220 | -380 | -570 | -740 |
| Permanently extend 10% capital reduction, Prospective Payment System neutral | | | -300 | -380 | -420 | -680 |
| Permanently extend Medicare Secondary Payer (MSP) for the disabled | | | -650 | -960 | -1,085 | -1,610 |
| Permanently extend MSP for End Stage Renal Disease after 18 months | | | -35 | -35 | -35 | -70 |
| Permanently extend Internal Revenue Service/Social Security Administration/Health Care Financing Administration data match | | | -45 | -120 | -205 | -165 |
| Permanently extend reduction of payments for hospital outpatient services by 5.8% | | | -425 | -525 | -600 | -950 |
| Third party liability—Enhance identification of other health coverage | | -150 | -250 | -400 | -450 | -800 |
| Direct medical education | -350 | -340 | -340 | -330 | -320 | -1,360 |

### TABLE 3. PROPOSED CHANGES TO MANDATORY PROGRAMS–Continued

(Outlays in millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Ban physician self referrals | .............. | -90 | -100 | -100 | -100 | -290 |
| Reduce default Medicare volume performance and update | .............. | .............. | -200 | -660 | -1,225 | -860 |
| Reduce doctor fees in 1994 except primary care | -200 | -300 | -350 | -400 | -435 | -1,250 |
| Provide electronic billing incentive | .............. | .............. | -90 | -175 | -175 | -265 |
| Outpatient department cut at 10% | .............. | .............. | -315 | -375 | -465 | -690 |
| Medicare—Maintain 1995 ratio of premium collections to program outlays with a 27% ceiling | .............. | .............. | -1,145 | -3,870 | -6,580 | -5,015 |
| **Subtotal, Controlling Health Care Costs** | -3,059 | -6,538 | -11,891 | -17,204 | -21,862 | -38,432 |
| **SHARED CONTRIBUTION** | | | | | | |
| Health: | | | | | | |
| Medicaid: Equate matching rates for welfare program | -160 | -400 | -440 | -480 | -540 | -1,480 |
| Social Security: | | | | | | |
| Retain Social Security threshold and tax 85% (revenue) | -2,700 | -5,600 | -6,200 | -6,900 | -7,700 | -21,400 |
| Income Security: | | | | | | |
| Strengthen child support enforcement | -27 | -80 | -112 | -109 | -177 | -328 |
| Equate matching rates for welfare program | -40 | -80 | -90 | -90 | -90 | -300 |
| End lump-sum benefit | .............. | .............. | -2,100 | -3,032 | -3,197 | -5,132 |
| **Subtotal, Shared Contribution** | -2,927 | -6,160 | -8,942 | -10,621 | -11,704 | -28,650 |
| **TOTAL, PROPOSED ENTITLEMENT SAVINGS** | -5,562 | -17,832 | -30,782 | -41,875 | -47,515 | -96,051 |
| **MEMORANDUM:** | | | | | | |
| Revenue items included above | -2,785 | -5,758 | -6,700 | -7,894 | -8,723 | -23,094 |

## TABLE 4. STIMULUS PROPOSALS

(In millions of dollars)

| | 1993 | | | 1994 outlays | 1995 outlays | 1996 outlays | 1997 outlays | 1998 outlays | Total 1994–1997 outlays |
|---|---|---|---|---|---|---|---|---|---|
| | Budget Authority | Obligations | Outlays | | | | | | |
| **INFRASTRUCTURE** | | | | | | | | | |
| Department of Defense—Civil: | | | | | | | | | |
| Army Corps of Engineers water projects | 94 | 94 | 28 | 66 | | | | | 66 |
| Department of Transportation: | | | | | | | | | |
| Federal highway program | | 2,976 | 316 | 1,898 | 405 | 100 | 64 | 60 | 2,467 |
| Airport improvement program | | 250 | 34 | 109 | 60 | 25 | 13 | 10 | 207 |
| AMTRAK | 188 | 188 | 28 | 131 | 28 | | | | 159 |
| Mass transit: | | | | | | | | | |
| Obligation limitation | | 16 | 1 | 3 | 5 | 3 | 3 | 1 | 14 |
| 1993 supplemental | 736 | 736 | 139 | 246 | 147 | 95 | 90 | 22 | 578 |
| Subtotal, Transportation | 924 | 4,166 | 518 | 2,387 | 645 | 223 | 170 | 92 | 3,425 |
| Department of Veterans Affairs: | | | | | | | | | |
| Maintenance backlog | 235 | 235 | 153 | 82 | | | | | 82 |
| SUBTOTAL, INFRASTRUCTURE | 1,253 | 4,495 | 699 | 2,535 | 645 | 223 | 170 | 92 | 3,571 |
| **SUMMER OF OPPORTUNITY** | | | | | | | | | |
| Department of Agriculture: | | | | | | | | | |
| Food and Nutrition Service: | | | | | | | | | |
| Women, Infants, and Children (WIC) supplemental feeding program | 75 | 75 | 68 | 7 | | | | | 7 |
| The Emergency Food Assistance Program (TEFAP) | 23 | 23 | 23 | | | | | | |
| Subtotal, Agriculture | 98 | 98 | 91 | 7 | | | | | 7 |
| Department of Education: | | | | | | | | | |
| Pell Grants unfunded shortfalls: | | | | | | | | | |
| Fund current law for 1993–1994 school year without borrowing from 1994 funds | 653 | 653 | | | | | | | |
| Fund shortfall caused in prior years without borrowing from 1994 funds | 1,371 | 1,371 | | | | | | | |
| Chapter 1: | | | | | | | | | |
| Census supplemental | 235 | 235 | 28 | 160 | 42 | 5 | | | 207 |
| Summer 1993 pre-school and school programs | 500 | 500 | 400 | 100 | | | | | 100 |
| Subtotal, Education | 2,759 | 2,759 | 428 | 260 | 42 | 5 | | | 307 |

## TABLE 4. STIMULUS PROPOSALS—Continued

(In millions of dollars)

| | 1993 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget Authority | Obligations | Outlays | 1994 outlays | 1995 outlays | 1996 outlays | 1997 outlays | 1998 outlays | Total 1994-1998 outlays |
| Department of Health and Human Services: | | | | | | | | | |
| Head Start: | | | | | | | | | |
| Head Start summer program | 500 | 500 | 425 | 75 | | | | | 75 |
| Childcare feeding (Agriculture) | 56 | 56 | 48 | 8 | | | | | 8 |
| Immunization | 300 | 300 | 236 | 64 | | | | | 64 |
| AIDS: Ryan White Act | 200 | 200 | 152 | 48 | | | | | 48 |
| Subtotal, Health and Human Services | 1,056 | 1,056 | 861 | 195 | | | | | 195 |
| Department of the Interior: | | | | | | | | | |
| Bureau of Indian Affairs: | | | | | | | | | |
| Enhanced school operations | 40 | 38 | 19 | 17 | 4 | | | | 21 |
| Department of Labor: | | | | | | | | | |
| Summer youth employment | 1,000 | 1,000 | 660 | 340 | | | | | 340 |
| Worker profiling | 14 | 14 | 9 | 5 | | | | | 5 |
| Community service employment for older Americans | 32 | 32 | 6 | 23 | 3 | | | | 26 |
| Extend Unemployment Compensation | 4,000 | 4,000 | 4,000 | | | | | | |
| Offsets: Extension lowers spending on Extended Benefits program | | | -800 | | | | | | |
| Subtotal, Labor | 5,046 | 5,046 | 3,875 | 368 | 3 | | | | 371 |
| Other Agencies: | | | | | | | | | |
| National Service program | 15 | 15 | 12 | 3 | | | | | 3 |
| Equal Employment Opportunity Commission | 9 | 9 | 8 | 1 | | | | | 1 |
| Small Business Administration: | | | | | | | | | |
| 7(a) loan guarantees—loan levels | (2,575) | (2,575) | | | | | | | |
| Loan subsidy | 141 | 141 | 42 | 99 | | | | | 99 |
| Subtotal, Other Agencies | 165 | 165 | 62 | 103 | | | | | 103 |
| SUBTOTAL, SUMMER OF OPPORTUNITY | 6,173 | 6,152 | 5,346 | 960 | 40 | 5 | | | 1,004 |
| TECHNOLOGY INVESTMENTS | | | | | | | | | |
| Department of Commerce: | | | | | | | | | |
| National Institute of Standards and Technology: | | | | | | | | | |
| Advanced technology program | 103 | 64 | 33 | 31 | 26 | 13 | | | 70 |
| Networking and computing applications | 14 | 14 | 11 | 3 | | | | | 3 |
| National Oceanic and Atmospheric Administration: Equipment acquisition | 81 | 81 | 67 | 14 | | | | | 14 |
| National Telecommunications and Information Administration: "Information Highways" | 64 | 38 | 3 | 31 | 30 | | | | 61 |
| Subtotal, Commerce | 262 | 197 | 114 | 79 | 56 | 13 | | | 148 |

**TABLE 4. STIMULUS PROPOSALS—Continued**

(In millions of dollars)

| | 1993 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget Authority | Obligations | Outlays | 1994 outlays | 1995 outlays | 1996 outlays | 1997 outlays | 1998 outlays | Total 1994-1998 outlays |
| Department of Health and Human Services: | | | | | | | | | |
| National Institutes of Health: | | | | | | | | | |
| Networking and computing applications | 9 | 9 | 6 | 3 | ........ | ........ | ........ | ........ | 3 |
| Social Security Administration: | | | | | | | | | |
| Disability Insurance (DI) processing | ........ | 302 | 302 | ........ | ........ | ........ | ........ | ........ | ........ |
| Subtotal, Health and Human Services | 9 | 311 | 308 | 3 | ........ | ........ | ........ | ........ | 3 |
| Department of the Treasury: | | | | | | | | | |
| Accelerate Tax System Modernization (TSM) | 148 | 148 | 104 | 44 | ........ | ........ | ........ | ........ | 44 |
| Other Agencies: | | | | | | | | | |
| National Aeronautics and Space Administration: | | | | | | | | | |
| Networking and computing applications | 5 | 4 | 3 | 2 | ........ | ........ | ........ | ........ | 2 |
| National Science Foundation | | | | | | | | | |
| Research and development | 189 | 150 | 85 | 75 | 28 | ........ | ........ | ........ | 103 |
| Networking and computing applications | 18 | 15 | 8 | 8 | 3 | ........ | ........ | ........ | 11 |
| Subtotal, NSF | 207 | 165 | 93 | 83 | 31 | ........ | ........ | ........ | 114 |
| Subtotal, Other agencies | 212 | 169 | 96 | 85 | 31 | ........ | ........ | ........ | 116 |
| SUBTOTAL, TECHNOLOGY INVESTMENTS | 631 | 615 | 622 | 211 | 87 | 13 | ........ | ........ | 311 |
| URBAN DEVELOPMENT AND HOUSING INITIATIVE | | | | | | | | | |
| Department of Commerce: | | | | | | | | | |
| Economic Development Administration | 94 | 94 | 9 | 29 | 29 | 18 | 7 | 2 | 83 |
| Minority Business Development Administration | 2 | 2 | 1 | 1 | ........ | ........ | ........ | ........ | 1 |
| Subtotal, Commerce | 96 | 96 | 10 | 30 | 29 | 18 | 7 | 2 | 84 |
| Department of Housing and Urban Development: | | | | | | | | | |
| Accelerate Home Investment Partnership | ........ | ........ | ........ | ........ | ........ | ........ | ........ | ........ | ........ |
| Accelerate Public Housing Modernization | ........ | ........ | 63 | 173 | 263 | 260 | 171 | 85 | 867 |
| Community Development Block Grants | 2,536 | 2,536 | 681 | 1,319 | 558 | ........ | ........ | ........ | 1,877 |
| Supportive Housing | 423 | 423 | 127 | 211 | 85 | ........ | ........ | ........ | 296 |
| Subtotal, HUD | 2,959 | 2,959 | 871 | 1,703 | 906 | 260 | 171 | 85 | 3,040 |
| Other Agencies: | | | | | | | | | |
| District of Columbia | 28 | 28 | 26 | ........ | ........ | ........ | ........ | ........ | ........ |
| SUBTOTAL, URBAN DEVELOPMENT AND HOUSING INITIATIVE | 3,083 | 3,083 | 907 | 1,733 | 935 | 278 | 178 | 87 | 3,124 |

TABLE 4. STIMULUS PROPOSALS—Continued

(In millions of dollars)

| | 1993 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget Authority | Obligations | Outlays | 1994 outlays | 1995 outlays | 1996 outlays | 1997 outlays | 1998 outlays | Total 1994-1997 outlays |
| **RURAL DEVELOPMENT INITIATIVE** | | | | | | | | | |
| Department of Agriculture: | | | | | | | | | |
| Soil Conservation Service: | | | | | | | | | |
| Watershed and conservation | 47 | 47 | 24 | 23 | | | | | 23 |
| Agricultural Research Service: | | | | | | | | | |
| Enhanced facility maintenance | 38 | 38 | 30 | 8 | | | | | 8 |
| Enhanced natural resource protection | 188 | 188 | 168 | 19 | | | | | 19 |
| FmHA Very Low-Income Housing Repair Loans: | | | | | | | | | |
| Loan levels | (3) | (3) | | | | | | | |
| Loan subsidy | 1 | 1 | 1 | | | | | | |
| FmHA very low-income housing repair grants | 6 | 6 | 5 | 1 | | | | | 1 |
| FmHA Single Family Housing Guaranteed Loans: | | | | | | | | | |
| Loan levels | (225) | (225) | | | | | | | |
| Loan subsidy | 5 | 5 | 4 | 1 | | | | | 1 |
| Food Safety and Inspection Service | 4 | 4 | 4 | | | | | | |
| Rural Development Administration: | | | | | | | | | |
| Loan levels | (470) | (470) | | | | | | | |
| Loan subsidy | 67 | 67 | 2 | 19 | 22 | 24 | | | 65 |
| Grants | 281 | 281 | 6 | 67 | 84 | 124 | | | 275 |
| Subtotal, Agriculture | 637 | 638 | 244 | 138 | 106 | 148 | | | 392 |
| Department of the Interior: | | | | | | | | | |
| Bureau of Indian Affairs: Economic development on Indian Reservations: | | | | | | | | | |
| Loan levels | (48) | (48) | | | | | | | |
| Loan subsidy | 6 | 6 | 6 | | | | | | |
| Road maintenance and facility repair | 33 | 33 | 30 | 4 | | | | | 4 |
| Subtotal, Interior | 39 | 39 | 36 | 4 | | | | | 4 |
| SUBTOTAL, RURAL DEVELOPMENT | 676 | 677 | 280 | 142 | 106 | 148 | | | 396 |
| **ENVIRONMENT/ENERGY** | | | | | | | | | |
| Department of Energy: | | | | | | | | | |
| National Laboratories (CRADAs) | 47 | 47 | 22 | 19 | 7 | | | | 26 |
| Increase weatherization grants | 47 | 47 | 14 | 26 | 7 | | | | 33 |
| Building and industrial conservation | 19 | 19 | 10 | 9 | | | | | 9 |
| Vehicle energy conversion | 28 | 28 | 28 | | | | | | |
| Subtotal, Energy | 141 | 141 | 74 | 54 | 14 | | | | 68 |

### TABLE 4. STIMULUS PROPOSALS–Continued

(In millions of dollars)

| | 1993 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget Authority | Obligations | Outlays | 1994 outlays | 1995 outlays | 1996 outlays | 1997 outlays | 1998 outlays | Total 1994-1997 outlays |
| Department of the Interior: | | | | | | | | | |
| Enhanced natural resource protection | 348 | 348 | 315 | 35 | ........ | ........ | ........ | ........ | 35 |
| National Park Service: Historic preservation | 23 | 23 | 14 | 9 | ........ | ........ | ........ | ........ | 9 |
| Subtotal, Interior | 372 | 372 | 329 | 44 | ........ | ........ | ........ | ........ | 44 |
| Other Agencies: | | | | | | | | | |
| Environmental Protection Agency: | | | | | | | | | |
| Watershed resource restoration grants | 47 | 47 | 23 | 15 | 8 | ........ | ........ | ........ | 23 |
| Green programs | 23 | 23 | 8 | 11 | 4 | ........ | ........ | ........ | 15 |
| Wastewater State revolving fund | 845 | 845 | 39 | 179 | 272 | 172 | 72 | 34 | 695 |
| Subtotal, EPA | 915 | 915 | 70 | 205 | 284 | 172 | 72 | 34 | 733 |
| Multi-Agency cross-cutting option: | | | | | | | | | |
| Federal buildings energy efficiency | 19 | 19 | 11 | 7 | 1 | ........ | ........ | ........ | 8 |
| Subtotal, Other agencies | 934 | 934 | 81 | 212 | 285 | 172 | 72 | 34 | 741 |
| SUBTOTAL, ENVIRONMENT/ENERGY | 1,447 | 1,447 | 484 | 310 | 289 | 172 | 72 | 34 | 853 |
| TAX INCENTIVES | | | | | | | | | |
| Investment tax credit and other tax stimulus provisions | 6,442 | 6,442 | 6,442 | ........ | ........ | ........ | ........ | ........ | ........ |
| TOTALS, ALL CATEGORIES | | | | | | | | | |
| SUBTOTAL, ALL SPENDING | 16,262 | 19,669 | 8,336 | 5,874 | 2,124 | 842 | 419 | 213 | 9,259 |
| SUBTOTAL, LOAN LEVELS | 3,331 | 3,331 | ........ | ........ | ........ | ........ | ........ | ........ | ........ |
| LESS LOAN SUBSIDY | -220 | -220 | ........ | ........ | ........ | ........ | ........ | ........ | ........ |
| SUBTOTAL, SPENDING + LOAN LEVELS | 19,373 | 22,780 | 8,336 | 5,874 | 2,124 | 842 | 419 | 213 | 9,259 |
| SUBTOTAL, TAX INCENTIVES | 6,442 | 6,442 | 6,442 | ........ | ........ | ........ | ........ | ........ | ........ |
| TOTAL | 25,815 | 29,222 | 14,778 | 5,874 | 2,124 | 842 | 419 | 213 | 9,259 |

## TABLE 5. INVESTMENT PROPOSALS

(In millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| **REBUILD AMERICA—INFRASTRUCTURE** | | | | | | |
| Transportation: | | | | | | |
| Federal-aid highway program | 402 | 1,736 | 1,847 | 1,831 | 1,402 | 5,816 |
| Smart cars/smart highways (part of Federal-aid highway obligations) | (70) | (85) | (90) | (100) | (100) | (345) |
| Mass transit formula capital grants | 23 | 149 | 398 | 639 | 864 | 1,209 |
| High-speed rail and MAGLEV | 27 | 140 | 221 | 258 | 305 | 646 |
| Alcohol-related highway safety and other transportation capital | 11 | 37 | 65 | 88 | 98 | 201 |
| Airport improvement program | 5 | 22 | 36 | 44 | 47 | 107 |
| Air traffic control modernization | 24 | 69 | 111 | 140 | 181 | 344 |
| Public land highways and Indian reservation roads | 5 | 38 | 99 | 153 | 200 | 295 |
| High-speed rail bonds (tax incentive) | | 1 | 4 | 11 | 20 | 16 |
| Subtotal, Transportation | 487 | 2,192 | 2,781 | 2,984 | 3,097 | 8,434 |
| Environment: | | | | | | |
| Drinking water state revolving funds (EPA) | 24 | 172 | 440 | 692 | 840 | 1,328 |
| Clean water state revolving funds (EPA) | 54 | 344 | 900 | 1,402 | 1,866 | 2,700 |
| Safety of dams on Indian reservations (Interior) | 4 | 12 | 20 | 23 | 23 | 59 |
| Water resources development (Corps of Engineers) | 77 | 147 | 160 | 160 | 160 | 544 |
| Watershed resource restoration (EPA) | 15 | 34 | 43 | 47 | 49 | 139 |
| Environmental restoration and waste management (DOE) | 8 | 35 | 70 | 107 | 148 | 220 |
| Forests for the Future (USDA) | 24 | 46 | 50 | 50 | 50 | 170 |
| Weather service modernization (NOAA) | 84 | 86 | 70 | 50 | -16 | 290 |
| Environmental technology (EPA) | 14 | 46 | 84 | 127 | 175 | 271 |
| Green programs (EPA) | 5 | 16 | 23 | 25 | 25 | 69 |
| Natural resource protection and environmental infrastructure (Interior and USDA) | 187 | 364 | 471 | 509 | 538 | 1,531 |
| Tree planting initiative (USDA) | 33 | 64 | 73 | 76 | 79 | 246 |
| National research initiative grants (USDA) | 2 | 16 | 60 | 110 | 160 | 188 |
| Forestry research initiative (USDA) | 16 | 56 | 84 | 105 | 122 | 261 |
| Subtotal, Environment | 527 | 1,458 | 2,548 | 3,483 | 4,017 | 8,016 |
| Rural Development Initiative: | | | | | | |
| Rural water and waste water loans and grants (USDA) | 6 | 42 | 107 | 176 | 207 | 331 |
| Business and community initiative (USDA) | 106 | 240 | 358 | 454 | 544 | 1,158 |
| Subtotal, Rural Development Initiative | 111 | 282 | 465 | 630 | 751 | 1,488 |
| Energy: | | | | | | |
| Alternative fuels vehicles | 18 | 30 | 30 | 30 | 30 | 108 |
| Energy efficiency in Federal buildings | 49 | 152 | 270 | 329 | 342 | 800 |
| Increase weatherization grants (DOE) | 18 | 63 | 94 | 100 | 100 | 275 |
| Close-out costs for DOE reactors | 18 | 8 | 9 | 3 | 1 | 38 |
| Energy conservation and renewable energy programs (Energy Policy Act) | 48 | 168 | 304 | 420 | 520 | 940 |
| Natural gas research and development: Emphasize utilization | 5 | 25 | 55 | 90 | 112 | 175 |
| Advanced neutron source | 11 | 50 | 116 | 243 | 436 | 420 |
| Fusion energy research | 9 | 39 | 72 | 90 | 95 | 210 |
| Subtotal, Energy | 176 | 535 | 950 | 1,305 | 1,636 | 2,966 |

### TABLE 5. INVESTMENT PROPOSALS—Continued

(In millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Community Development and Defense Conversion: | | | | | | |
| Community development block grant (CDBG) | 4 | 41 | 100 | 137 | 148 | 282 |
| Office of Economic Adjustment for defense reinvestment and transition | 9 | 17 | 20 | 20 | 20 | 66 |
| Economic Development Administration for defense reinvestment and transition | 3 | 16 | 33 | 44 | 53 | 96 |
| Enterprise zones (tax incentive) | 73 | 347 | 772 | 1,228 | 1,699 | 2,420 |
| Community development banks | 45 | 93 | 106 | 110 | 114 | 354 |
| **Subtotal, Community Development and Defense Conversion** | 134 | 514 | 1,031 | 1,539 | 2,034 | 3,218 |
| Technology and Business Reinvestment and Defense Conversion: | | | | | | |
| NASA civil aviation | 36 | 121 | 171 | 222 | 267 | 550 |
| NASA short-haul aircraft research | 3 | 10 | 17 | 20 | 20 | 50 |
| Dual-use technology for defense reinvestment and transition (DOD) | 133 | 322 | 420 | 456 | 480 | 1,331 |
| Federal Coordinating Council for Science, Engineering, and Technology (research initiatives) | 100 | 266 | 383 | 457 | 514 | 1,206 |
| Crosscutting high performance computing (NSF, NIH, NASA, and NIST) | 53 | 158 | 253 | 320 | 362 | 784 |
| National Inst of Standards and Technology growth | 56 | 219 | 403 | 628 | 805 | 1,306 |
| National labs (non-defense) | 14 | 35 | 47 | 50 | 50 | 146 |
| Information highways (Commerce) | 8 | 42 | 96 | 129 | 150 | 275 |
| National Science Foundation | 134 | 451 | 758 | 954 | 1,100 | 2,297 |
| Government automation and efficiency | 204 | 652 | 850 | 943 | 735 | 2,649 |
| Extend R&E tax credit (tax incentive) | 1,207 | 1,503 | 1,750 | 1,977 | 2,200 | 6,437 |
| **Subtotal, Technology and Business Reinvestment and Defense Conversion** | 1,946 | 3,779 | 5,150 | 6,156 | 6,683 | 17,031 |
| Housing: | | | | | | |
| 100% vouchers (100,000 units) | 7 | 65 | 222 | 422 | 654 | 716 |
| Preservation and restoration of assisted housing | 37 | 155 | 282 | 384 | 519 | 858 |
| Supportive housing program | | 22 | 81 | 138 | 183 | 241 |
| Mortgage revenue bonds (tax incentive) | 104 | 145 | 160 | 172 | 174 | 581 |
| Extend low-income housing tax credit (tax incentive) | 214 | 478 | 791 | 1,114 | 1,442 | 2,597 |
| Real estate investment (tax incentive) | 254 | 387 | 164 | 17 | -158 | 822 |
| Urban Partnership Against Crime | 6 | 52 | 118 | 136 | 133 | 312 |
| Severely distressed public housing | | 17 | 68 | 121 | 167 | 206 |
| HOPE youthbuild | | 5 | 19 | 34 | 48 | 58 |
| **Subtotal, Housing** | 622 | 1,326 | 1,905 | 2,540 | 3,162 | 6,391 |
| SUBTOTAL, TAX INCENTIVES | 1,852 | 2,861 | 3,641 | 4,519 | 5,377 | 12,873 |
| SUBTOTAL, SPENDING INCENTIVES | 2,161 | 7,225 | 11,185 | 14,098 | 16,006 | 34,669 |
| TOTAL, REBUILD AMERICA | 4,013 | 10,086 | 14,826 | 18,617 | 21,383 | 47,542 |

### TABLE 5. INVESTMENT PROPOSALS–Continued

(In millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| **LIFELONG LEARNING** | | | | | | |
| WIC (Special supplemental food program for women, infants, and children) | 318 | 532 | 800 | 984 | 1,000 | 2,634 |
| Parenting and Family Support | 40 | 85 | 230 | 495 | 600 | 850 |
| Head Start | 932 | 1,886 | 2,790 | 3,676 | 4,562 | 9,284 |
| Child Care and Development Block Grant | 30 | 95 | 145 | 200 | 250 | 470 |
| Education Reform and Initiatives | 206 | 1,043 | 2,206 | 2,697 | 3,083 | 6,152 |
| Employer Provided Education Assistance (tax incentive) | 425 | 458 | 492 | 528 | 565 | 1,903 |
| National Service | 98 | 1,042 | 1,890 | 3,000 | 3,400 | 6,030 |
| Worker Training Initiatives: | | | | | | |
| Dislocated Worker Assistance Act (for NAFTA, Defense Reinvestment and Transition, Energy Conversion, and Trade Adjustment) | 60 | 879 | 1,699 | 1,960 | 2,000 | 4,598 |
| Job Corps: adopt "50–50 plan" | 11 | 32 | 96 | 202 | 344 | 341 |
| Job Corps: eliminate maintenance backlog | 7 | 20 | 32 | 45 | 50 | 104 |
| JTPA, summer youth employment and training | 247 | 540 | 625 | 625 | 625 | 2,037 |
| One-stop career shopping | 30 | 170 | 250 | 250 | 250 | 700 |
| Older Americans employment | 4 | 22 | 34 | 35 | 35 | 95 |
| Youth apprenticeship | 32 | 243 | 448 | 495 | 500 | 1,218 |
| Worker profiling | 6 | 3 | | | | 9 |
| Targeted jobs tax credit (tax incentive) | 170 | 327 | 406 | 496 | 605 | 1,399 |
| Subtotal, Worker Training Initiatives | 567 | 2,236 | 3,590 | 4,108 | 4,409 | 10,501 |
| SUBTOTAL, TAX INCENTIVES | 595 | 785 | 898 | 1,024 | 1,170 | 3,302 |
| SUBTOTAL, SPENDING INCENTIVES | 2,021 | 6,592 | 11,245 | 14,664 | 16,699 | 34,522 |
| TOTAL, LIFELONG LEARNING | 2,616 | 7,377 | 12,143 | 15,688 | 17,869 | 37,824 |
| **REWARDING WORK** | | | | | | |
| Earned income tax credit (tax incentive) | 525 | 6,228 | 6,445 | 6,662 | 6,927 | 19,860 |
| Extension of unemployment compensation | 2,400 | | | | | 2,400 |
| Crime Initiative, including Community Policing, Criminal Records Upgrades, and Police Corps | 210 | 521 | 725 | 842 | 918 | 2,298 |
| Equal Employment Opportunity Commission | 10 | 17 | 18 | 18 | 18 | 63 |
| SUBTOTAL, TAX INCENTIVES | 525 | 6,228 | 6,445 | 6,662 | 6,927 | 19,860 |
| SUBTOTAL, SPENDING INCENTIVES | 2,620 | 538 | 743 | 860 | 936 | 4,761 |
| TOTAL, REWARDING WORK | 3,145 | 6,766 | 7,188 | 7,522 | 7,863 | 24,621 |
| **HEALTH CARE** | | | | | | |
| AIDS, women's health, immunizations, NIH research, and other public health initiatives | 348 | 1,660 | 2,806 | 3,370 | 4,251 | 8,182 |
| AIDS—Ryan White Act | 60 | 192 | 305 | 392 | 445 | 949 |
| Substance abuse prevention and treatment | 46 | 207 | 456 | 797 | 933 | 1,506 |
| Food safety initiative (USDA) and emergency food assistance | 54 | 98 | 101 | 102 | 103 | 355 |
| Food Stamps | 1,000 | 2,000 | 3,000 | 3,000 | 3,000 | 9,000 |
| Low-income Home Energy Assistance Program | | 316 | 649 | 982 | 998 | 1,947 |

### TABLE 5. INVESTMENT PROPOSALS–Continued

(In millions of dollars)

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|
| Rural Health Initiative | 50 | 55 | 10 | | | 115 |
| VA medical care | 279 | 663 | 733 | 800 | 861 | 2,475 |
| Improving disability insurance processing | 120 | 200 | 200 | 200 | 200 | 720 |
| Health Insurance Deduction for Self-employed (tax incentive) | 313 | | | | | 313 |
| SUBTOTAL, TAX INCENTIVES | 313 | | | | | 313 |
| SUBTOTAL, SPENDING INCENTIVES | 1,955 | 5,391 | 8,260 | 9,643 | 10,791 | 25,249 |
| TOTAL, HEALTH CARE | 2,268 | 5,391 | 8,260 | 9,643 | 10,791 | 25,562 |
| **PRIVATE-SECTOR INCENTIVES** | | | | | | |
| Investment Tax Incentives: | | | | | | |
| Targeted capital gains exclusion (tax incentive) | 12 | 93 | 155 | 207 | 247 | 467 |
| Earned income tax credit (EITC) (tax incentive) | (525) | (6,228) | (6,445) | (6,662) | (6,927) | (19,860) |
| Mortgage revenue bonds (tax incentive) | (104) | (145) | (160) | (172) | (174) | (581) |
| High-speed rail bonds (tax incentive) | | (1) | (4) | (11) | (20) | (16) |
| Extend R&E tax credit (tax incentive) | (1,207) | (1,503) | (1,750) | (1,977) | (2,200) | (6,437) |
| Extend low-income housing tax credit (tax incentive) | (214) | (478) | (791) | (1,114) | (1,442) | (2,597) |
| Small business investment tax credit (tax incentive) | 2,795 | 3,133 | 3,027 | 3,309 | 3,501 | 12,264 |
| Alternative minimum tax depreciation preference (tax incentive) | 188 | 307 | 396 | 404 | 273 | 1,295 |
| Temporary incremental investment tax credit (tax incentive) | 6,399 | 3,584 | 107 | -961 | -572 | 9,129 |
| Small issue manufacturing bonds (tax incentive) | 14 | 28 | 35 | 37 | 37 | 114 |
| Alternative minimum tax exception for gifts of appreciated property (tax incentive) | 70 | 73 | 75 | 77 | 79 | 295 |
| Railroad retirement fund transfer (tax incentive) | | | | | | |
| Small business credit availability | 60 | 131 | 153 | 157 | 160 | 501 |
| SUBTOTAL, TAX INCENTIVES | 9,478 | 7,218 | 3,795 | 3,073 | 3,565 | 23,564 |
| SUBTOTAL, SPENDING INCENTIVES | 60 | 131 | 153 | 157 | 160 | 501 |
| TOTAL, PRIVATE-SECTOR INCENTIVES | 9,538 | 7,349 | 3,948 | 3,230 | 3,725 | 24,065 |
| TAX INCENTIVES, ALL CATEGORIES | 12,763 | 17,092 | 14,779 | 15,278 | 17,039 | 59,912 |
| SPENDING INCENTIVES, ALL CATEGORIES | 8,817 | 19,877 | 31,586 | 39,422 | 44,592 | 99,702 |
| TOTAL, ALL CATEGORIES | 21,580 | 36,969 | 46,365 | 54,700 | 61,631 | 159,614 |

## TABLE 6. REVENUE AND RECEIPTS PROPOSALS

(In billions of dollars)

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1994–1997 Total |
|---|---|---|---|---|---|---|---|
| **Revenue Raising Proposals:** | | | | | | | |
| Raise individual income taxes for upper incomes | 1.8 | 27.7 | 19.9 | 22.9 | 26.3 | 27.7 | 96.8 |
| Repeal HI taxable wage base | | 2.3 | 6.0 | 6.4 | 6.8 | 7.2 | 22.0 |
| Increase top income tax rate on large corporations to 36% | 0.4 | 7.7 | 5.4 | 5.5 | 5.7 | 5.8 | 24.4 |
| Broad based energy tax [1] | | 1.5 | 8.9 | 16.4 | 22.3 | 22.4 | 49.0 |
| Cap possessions tax credit (sec. 936) at 65% of wages | | 0.2 | 0.9 | 1.6 | 2.1 | 2.2 | 4.8 |
| Service industry non-compliance initiative | | 0.1 | 0.6 | 1.3 | 1.9 | 2.2 | 4.0 |
| Tax Identification Number (TIN) validation | | * | * | * | 0.1 | 0.1 | 0.1 |
| Disallow unreasonable claims | | 0.3 | 0.6 | 0.4 | 0.3 | 0.3 | 1.6 |
| Restrict deduction for business meals and entertainment to 50% | | 1.8 | 3.2 | 3.4 | 3.7 | 4.0 | 12.1 |
| Reduce pension compensation cap | | 0.3 | 0.8 | 0.8 | 0.9 | 0.9 | 2.7 |
| Mark to market for security dealers | | 0.5 | 1.1 | 1.1 | 1.1 | 0.7 | 3.8 |
| Disallow moving deductions for meals and real-estate expenses | | 0.1 | 0.4 | 0.4 | 0.4 | 0.4 | 1.3 |
| Extend 2.5 cent per gallon gas tax | | | | 2.6 | 2.6 | 2.6 | 5.2 |
| Extend 53% and 55% estate tax rate | | 0.5 | 0.5 | 0.6 | 0.6 | 0.6 | 2.1 |
| Deny deduction for club dues | | 0.1 | 0.2 | 0.3 | 0.3 | 0.3 | 0.9 |
| Prohibit double-dip related to FSLIC assistance | 0.8 | 0.6 | 0.1 | * | 0.2 | 0.1 | 0.9 |
| Deny lobbying deductions | | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.7 |
| Deny deduction for executive pay over $1 million | -* | 0.1 | 0.1 | 0.1 | 0.2 | 0.1 | 0.5 |
| International tax provisions | * | 0.8 | 1.6 | 1.9 | 2.1 | 2.2 | 6.5 |
| Miscellaneous revenue raising provisions | | 0.8 | 0.1 | -0.2 | 0.2 | 0.2 | 1.0 |
| Subtotal, revenue raising proposals | 2.9 | 46.1 | 50.6 | 65.9 | 77.9 | 80.3 | 240.4 |
| Investment/stimulus | -6.4 | -12.8 | -17.1 | -14.8 | -15.3 | -17.0 | -59.9 |
| Total, net revenue proposals | -3.6 | 33.3 | 33.5 | 51.1 | 62.6 | 63.3 | 180.5 |
| **Other provisions affecting receipts:** | | | | | | | |
| IRS initiative | | * | 0.1 | 0.3 | 0.6 | 0.6 | 0.9 |
| Commodity Futures Trading Commission fee | | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 |
| Harbor maintenance tax | | * | * | 0.1 | 0.1 | 0.1 | 0.2 |
| Inland waterway tax | | * | 0.1 | 0.2 | 0.5 | 0.5 | 0.8 |
| SEC registration fee | | * | * | * | * | 0.1 | 0.2 |
| Federal [illegible]ry raise (receipt effect) | | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.4 |
| Federal FTE levels (receipt effect) | | -* | -0.1 | -0.1 | -0.1 | -0.1 | -0.2 |
| Total, other provisions | | 0.1 | 0.2 | 0.5 | 1.0 | 1.0 | 1.7 |
| **Addendum:** | | | | | | | |
| Total, net revenue proposals | -3.6 | 33.3 | 33.5 | 51.1 | 62.6 | 63.3 | 180.5 |
| Total, other provisions | | 0.1 | 0.2 | 0.5 | 1.0 | 1.0 | 1.7 |
| Tax 85% of social security benefits | | 2.7 | 5.6 | 6.2 | 6.9 | 7.7 | 21.4 |
| Corporate estimated tax rules | | | | | 3.9 | 0.8 | 3.9 |
| TOTAL, REVENUE AND RECEIPTS PROPOSALS | -3.6 | 36.1 | 39.3 | 57.8 | 74.4 | 72.8 | 207.5 |

* $50 million or less.

[1] The impact of this proposal is offset for low-income families by increases in the low-income home energy assistance program and food stamps that are reflected elsewhere.

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### TABLE 7. BUDGET OUTLAYS BY FUNCTION

(In billions of dollars)

| Function | Estimate | | | | | |
|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
| National defense | 292.9 | 277.3 | 272.3 | 264.9 | 249.2 | 252.7 |
| International affairs | 19.3 | 18.7 | 18.7 | 18.2 | 18.0 | 18.4 |
| General science, space and technology | 17.2 | 18.1 | 19.7 | 20.7 | 21.6 | 22.2 |
| Energy | 4.9 | 3.4 | 4.1 | 4.5 | 4.2 | 4.0 |
| Natural resources and environment | 22.1 | 21.9 | 22.8 | 23.3 | 23.7 | 23.7 |
| Agriculture | 21.6 | 16.1 | 13.8 | 12.2 | 10.9 | 11.5 |
| Commerce and housing credit | 13.6 | 14.0 | 0.6 | -10.5 | -10.2 | -7.0 |
| Transportation | 35.9 | 39.5 | 40.4 | 41.3 | 42.7 | 43.7 |
| Community and regional development | 10.8 | 11.1 | 10.4 | 9.7 | 9.5 | 9.7 |
| Education, training, employment, and social services | 53.4 | 53.8 | 56.6 | 56.1 | 62.7 | 65.5 |
| Health | 105.3 | 118.3 | 133.3 | 149.6 | 166.8 | 185.4 |
| Medicare | 132.7 | 147.2 | 162.8 | 179.0 | 195.2 | 213.6 |
| Income security | 208.8 | 214.3 | 221.5 | 229.7 | 240.4 | 249.1 |
| Social security | 305.0 | 321.0 | 335.7 | 351.3 | 367.4 | 383.1 |
| Veterans benefits and services | 35.7 | 37.6 | 37.5 | 37.0 | 39.1 | 40.0 |
| Administration of justice | 15.3 | 15.9 | 17.2 | 17.4 | 17.7 | 18.2 |
| General government | 14.8 | 14.4 | 15.6 | 15.5 | 15.7 | 15.8 |
| Net interest | 202.1 | 212.0 | 227.2 | 243.3 | 257.4 | 272.7 |
| Allowances | * | -3.3 | -6.1 | -7.2 | -8.9 | -9.1 |
| Undistributed offsetting receipts | -37.3 | -39.0 | -40.7 | -43.2 | -45.6 | -48.1 |
| Total outlays | 1,475.1 | 1,513.0 | 1,564.5 | 1,612.6 | 1,677.5 | 1,767.0 |

* $50 million or less.

## TABLE 8. BUDGET OUTLAY TOTALS BY AGENCY

(In billions of dollars)

| | | | Estimate | | | |
|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
| **Cabinet Agencies:** | | | | | | |
| Agriculture | 67.0 | 63.6 | 63.9 | 65.2 | 65.0 | 65.9 |
| Commerce | 3.1 | 3.2 | 3.4 | 3.7 | 3.9 | 4.2 |
| Defense | 279.5 | 284.1 | 256.9 | 251.4 | 236.8 | 239.5 |
| Education | 30.9 | 31.0 | 30.6 | 28.6 | 30.2 | 30.8 |
| Energy | 16.9 | 15.8 | 16.9 | 17.0 | 16.8 | 16.9 |
| Health and Human Services | 591.7 | 639.6 | 688.3 | 736.2 | 789.8 | 845.4 |
| Housing and Urban Development | 26.0 | 25.9 | 29.9 | 29.9 | 30.2 | 30.7 |
| Interior | 7.5 | 7.2 | 7.1 | 7.2 | 7.1 | 7.3 |
| Justice | 10.5 | 10.4 | 11.0 | 10.8 | 10.5 | 10.8 |
| Labor | 46.8 | 37.8 | 36.1 | 37.6 | 38.4 | 39.1 |
| State | 5.7 | 5.6 | 5.7 | 5.9 | 5.9 | 6.1 |
| Transportation | 36.5 | 39.2 | 39.6 | 40.4 | 41.6 | 42.6 |
| Treasury | 302.4 | 319.9 | 344.6 | 368.9 | 390.7 | 414.6 |
| Veterans Affairs | 35.4 | 37.1 | 38.4 | 35.6 | 37.7 | 38.4 |
| **Major Agencies:** | | | | | | |
| Corps of Engineers, Military Retirement and Other Defense | 29.5 | 30.7 | 31.8 | 33.1 | 34.2 | 35.4 |
| Deposit Insurance Agencies | 6.9 | 7.8 | -4.2 | -12.7 | -11.6 | -7.5 |
| Environmental Protection Agency | 6.5 | 6.7 | 6.9 | 7.0 | 7.2 | 7.4 |
| Executive Office of the President | 0.2 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 |
| Federal Emergency Management Agency | 3.2 | 1.8 | 1.2 | 0.9 | 0.8 | 0.7 |
| Funds Appropriated to the President | 11.9 | 11.8 | 11.5 | 11.1 | 10.8 | 10.8 |
| General Services Administration | 1.3 | 0.9 | 1.4 | 0.4 | 0.3 | 0.1 |
| Judicial Branch | 2.6 | 2.6 | 2.7 | 2.8 | 2.9 | 3.0 |
| Legislative Branch | 2.8 | 2.9 | 3.0 | 3.1 | 3.2 | 3.3 |
| National Aeronautics and Space Administration | 14.1 | 14.7 | 15.5 | 15.9 | 16.3 | 16.6 |
| National Science Foundation | 2.9 | 3.0 | 3.3 | 3.7 | 4.0 | 4.2 |
| Office of Personnel Management | 37.2 | 38.6 | 39.9 | 43.6 | 46.6 | 49.3 |
| Postal Service | 1.6 | 2.2 | 1.3 | -0.6 | -1.0 | -1.3 |
| Railroad Retirement Board | 4.7 | 4.7 | 4.7 | 4.7 | 4.7 | 4.7 |
| Small Business Administration | 1.0 | 0.8 | 0.4 | 0.4 | 0.4 | 0.4 |
| All Other Agencies | 7.8 | 7.7 | 9.3 | 8.3 | 8.5 | 9.2 |
| Undistributed Offsetting Receipts | -119.3 | -127.5 | -136.0 | -144.6 | -153.9 | -162.0 |
| Total outlays | 1,475.1 | 1,513.0 | 1,564.5 | 1,612.8 | 1,677.8 | 1,767.0 |

## TABLE 9. TOTAL FULL-TIME EQUIVALENT EMPLOYMENT

(Full-time equivalent employment in thousands)

| Agency | 1993 base | Estimate 1993 | 1994 | 1995 | 1996 | 1997 | 1993 base to 1997 change |
|---|---|---|---|---|---|---|---|
| **Cabinet Agencies:** | | | | | | | |
| Agriculture | 112.5 | 111.4 | 109.7 | 108.0 | 107.0 | 105.4 | -7.0 |
| Commerce | 36.4 | 36.0 | 35.5 | 34.9 | 34.9 | 34.9 | -1.5 |
| Defense | 927.2 | 917.8 | 885.2 | 865.2 | 842.2 | 832.2 | -95.0 |
| Education | 5.0 | 4.9 | 4.8 | 4.8 | 4.8 | 4.8 | -0.2 |
| Energy | 20.0 | 19.8 | 19.5 | 19.2 | 19.2 | 19.2 | -0.8 |
| Health and Human Services | 130.0 | 128.7 | 126.7 | 124.8 | 124.8 | 124.8 | -5.2 |
| Housing and Urban Development | 13.5 | 13.4 | 13.2 | 12.9 | 12.9 | 12.9 | -0.6 |
| Interior | 77.9 | 77.2 | 76.0 | 74.8 | 74.8 | 74.8 | -3.1 |
| Justice | 98.4 | 97.4 | 95.9 | 94.4 | 94.4 | 94.4 | -3.9 |
| Labor | 19.8 | 19.6 | 19.3 | 19.0 | 19.0 | 19.0 | -0.8 |
| State | 26.0 | 25.8 | 25.4 | 25.0 | 25.0 | 25.0 | -1.0 |
| Transportation | 71.1 | 70.4 | 69.3 | 68.2 | 68.2 | 68.2 | -2.8 |
| Treasury | 163.2 | 161.6 | 159.1 | 156.7 | 156.7 | 156.7 | -6.5 |
| Veterans Affairs | 230.4 | 228.1 | 224.6 | 221.2 | 221.2 | 221.2 | -9.2 |
| **Other Agencies:** | | | | | | | |
| Agency for International Development | 4.4 | 4.3 | 4.3 | 4.2 | 4.2 | 4.2 | -0.2 |
| Corps of Engineers | 27.4 | 27.2 | 26.8 | 26.3 | 26.3 | 26.3 | -1.1 |
| Environmental Protection Agency | 17.9 | 17.7 | 17.5 | 17.2 | 17.2 | 17.2 | -0.7 |
| Equal Employment Opportunity Commission | 2.8 | 2.8 | 2.8 | 2.7 | 2.7 | 2.7 | -0.1 |
| Federal Emergency Management Agency | 2.7 | 2.6 | 2.6 | 2.5 | 2.5 | 2.5 | -0.1 |
| Financial Institutions (FDIC/RTC) | 16.1 | 15.9 | 15.2 | 13.6 | 11.3 | 8.8 | -7.2 |
| General Services Administration | 22.7 | 22.5 | 22.1 | 21.8 | 21.8 | 21.8 | -0.9 |
| National Aeronautics and Space Administration | 24.9 | 24.7 | 24.3 | 23.9 | 23.9 | 23.9 | -1.0 |
| National Archives and Records Administration | 2.8 | 2.7 | 2.7 | 2.6 | 2.6 | 2.6 | -0.1 |
| National Labor Relations Board | 2.1 | 2.1 | 2.1 | 2.1 | 2.1 | 2.1 | -0.1 |
| Nuclear Regulatory Commission | 3.4 | 3.3 | 3.3 | 3.2 | 3.2 | 3.2 | -0.1 |
| Office of Personnel Management | 6.1 | 6.0 | 5.9 | 5.9 | 5.9 | 5.9 | -0.2 |
| Panama Canal Commission | 8.7 | 8.6 | 8.5 | 8.4 | 8.4 | 8.4 | -0.3 |
| Securities and Exchange Commission | 2.7 | 2.7 | 2.7 | 2.6 | 2.6 | 2.6 | -0.1 |
| Small Business Administration | 4.7 | 4.6 | 4.6 | 4.5 | 4.5 | 4.5 | -0.2 |
| Smithsonian Institution | 4.9 | 4.8 | 4.8 | 4.7 | 4.7 | 4.7 | -0.2 |
| Tennessee Valley Authority | 19.1 | 18.6 | 18.5 | 18.4 | 18.4 | 18.4 | -0.8 |
| United States Information Agency | 8.7 | 8.6 | 8.5 | 8.3 | 8.3 | 8.3 | -0.3 |
| Other small agencies | 22.0 | 21.8 | 21.3 | 20.9 | 20.9 | 20.8 | -1.2 |
| **Total, executive branch** | 2,135.5 | 2,113.7 | 2,072.5 | 2,023.3 | 1,996.8 | 1,982.7 | -152.8 |
| FTE reduction from the base | | 21.8 | 63.0 | 112.2 | 138.7 | 152.8 | |
| Percentage reduction from the base | | 1.0 | 2.9 | 5.3 | 6.5 | 7.2 | |
| Percentage reduction target/1993-1997 FTE reduction target | | 1.0 | 2.5 | 4.0 | 4.0 | 4.0 | -100.0 |

## TABLE 10. BUDGET BY BEA CATEGORY

(In billions of dollars)

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|---|
| Discretionary: | | | | | | |
| Defense | 294.3 | 277.8 | 273.1 | 265.5 | 249.7 | 253.3 |
| Nondefense | 261.7 | 270.4 | 282.1 | 292.6 | 302.4 | 312.5 |
| Subtotal, Discretionary | 556.0 | 548.2 | 555.2 | 558.1 | 552.1 | 565.8 |
| Mandatory | 717.0 | 752.7 | 782.1 | 811.5 | 868.0 | 928.5 |
| Net Interest | 202.1 | 212.0 | 227.2 | 243.3 | 257.4 | 272.7 |
| Total, Outlays | 1,475.1 | 1,513.0 | 1,564.5 | 1,612.8 | 1,677.5 | 1,767.0 |
| Revenues | 1,143.2 | 1,250.5 | 1,322.8 | 1,407.5 | 1,471.0 | 1,525.6 |
| Deficit | 331.9 | 262.5 | 241.7 | 205.3 | 206.5 | 241.4 |
| Addendum: | | | | | | |
| On-Budget Deficit (+) | 376.7 | 324.0 | 314.0 | 291.6 | 301.4 | 347.3 |
| Off-Budget Surplus (-) | -44.9 | -61.6 | -72.3 | -86.3 | -94.9 | -105.9 |

## TABLE 11. CHANGE FROM JANUARY TO CURRENT BASELINE

(In billions of dollars)

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|---|
| January Uncapped Baseline Deficit | 327.3 | 309.1 | 307.1 | 324.4 | 384.1 | 426.4 |
| Bush defense proposals [1] | 0.0 | -4.2 | -9.8 | -16.3 | -22.3 | -28.7 |
| Uncapped Baseline with Bush defense | 327.3 | 304.9 | 297.2 | 308.1 | 361.8 | 397.7 |
| Changes due to revised economic assumptions: | | | | | | |
| Discretionary inflation: | | | | | | |
| Defense | 0.0 | -0.5 | -1.9 | -4.2 | -7.0 | -9.9 |
| Nondefense | 0.0 | -0.4 | -1.7 | -3.7 | -6.1 | -8.7 |
| Mandatory outlays | -1.3 | -2.2 | -7.2 | -15.9 | -24.7 | -35.0 |
| Net interest: | | | | | | |
| Rates | -0.5 | -6.7 | -13.4 | -15.5 | -17.9 | -22.0 |
| Debt service | 0.1 | 0.2 | 0.3 | -0.1 | -0.9 | -1.5 |
| Subtotal, outlays | -1.7 | -9.5 | -24.0 | -39.4 | -56.5 | -77.1 |
| Receipts (+ equals decrease) | 4.4 | 12.7 | 21.6 | 28.2 | 42.7 | 70.1 |
| Subtotal, changes due to revised economic assumptions | 2.7 | 3.2 | -2.4 | -11.2 | -13.8 | -7.0 |
| Changes due to technical reestimates: | | | | | | |
| Defense discretionary | 3.6 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Nondefense discretionary | -1.3 | -0.3 | -1.3 | -2.3 | -2.3 | -2.6 |
| Mandatory: | | | | | | |
| Deposit insurance | -8.6 | -8.2 | 3.1 | 2.4 | 0.1 | -0.4 |
| Other | -0.4 | -1.4 | -1.4 | -0.8 | -0.5 | -1.4 |
| Subtotal, mandatory | -9.0 | -9.6 | 1.7 | 1.6 | -0.5 | -1.8 |
| Net interest: | | | | | | |
| FFB (deposit insurance and other) | 0.2 | 0.9 | 1.2 | 1.1 | 1.0 | 1.0 |
| Interest on the public debt | -0.4 | -0.1 | * | 0.4 | 1.1 | 3.8 |
| Debt service | -0.3 | -0.8 | -1.1 | -1.2 | -1.5 | -1.8 |
| Subtotal, outlays | -7.2 | -9.9 | 0.6 | -0.4 | -2.1 | -1.5 |
| Receipts (+ equals decrease) | -3.6 | 3.2 | 0.5 | 0.6 | 0.4 | 0.5 |
| Subtotal, changes due to technical reestimates | -10.8 | -6.8 | 1.0 | 0.2 | -1.7 | -1.0 |
| Total, changes due to revised economic assumptions and technical reestimates | -8.1 | -3.6 | -1.3 | -11.0 | -15.5 | -8.0 |
| Current Baseline Deficit | 319.2 | 301.3 | 295.9 | 297.0 | 346.3 | 389.7 |

* $50 million or less.

[1] Includes related debt service.

### TABLE 12. CHANGE IN THE STRUCTURAL DEFICIT

(Fiscal years, in billions of dollars)

| | Estimate | | | | | |
|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
| **Baseline deficit** | **319.2** | **301.3** | **295.9** | **297.0** | **346.3** | **389.7** |
| Cyclical component | 66.8 | 51.6 | 36.3 | 24.0 | 16.8 | 16.1 |
| Deposit insurance | 6.9 | 7.9 | -4.0 | -12.5 | -11.3 | -7.3 |
| **Baseline structural deficit** | **245.5** | **241.8** | **263.6** | **285.5** | **340.8** | **380.9** |
| Effect of policy proposals | 12.7 | -38.9 | -54.2 | -91.7 | -139.8 | -148.3 |
| **Proposed structural deficit** | **258.2** | **202.9** | **209.4** | **193.8** | **201.0** | **232.6** |

# Summary

Over the last 25 years, the health sector's share of the U.S. economy has more than doubled. In 1965, national health spending constituted less than 6 percent of the gross domestic product (GDP), but by 1990 it had expanded to more than 12 percent of GDP. Assuming that current government policies remain in force, and that medical practice and private health insurance trends continue, the Congressional Budget Office (CBO) projects that national health spending will reach 18 percent of GDP by the year 2000, or almost $1.7 trillion. As health spending continues to grow, concerns mount about its financial impacts on consumers, businesses, and governments.

Despite recent weakness in the economy, employment and incomes in the health sector have increased at striking rates. The total number of jobs in the health sector of the economy increased by 639,000 from May 1990 through May 1992, while the total number of jobs in the economy fell by almost 1.8 million and the number of nonhealth jobs fell by 2.4 million. According to the American Medical Association, the average net income of physicians (after subtracting office expenses, malpractice insurance premiums, and the like) in 1990 was $164,000, up from $98,000 in 1982--an average annual growth rate of 6.6 percent. By comparison, the average pay of all full-time workers increased from $18,500 to $25,900 during the same period, a growth rate of only 4.3 percent a year. Similarly, community hospital margins (the net of revenues less expenses) reported by the American Hospital Association were 5.2 percent in 1991, higher than their 20-year average of 4.2 percent.

Health expenditures generally grow more rapidly than spending in most other parts of the economy, largely because of what economists call market failure. This failure has allowed rapid technological change that tends to inflate rather than save costs, an unrelenting expansion of services provided during each doctor visit or hospital stay, and large increases in fees paid to health care providers. The aging of the U.S. population contributes to higher spending on health care because older patients use a disproportionate amount of health services, but in the next decade the impact of the aging population will increase health spending only modestly. Increases in hospital stays and physician visits that can be expected because the population is aging are likely to account for only a small part of increased health spending.

Health insurance, the nation's primary method of financing health care, is one source of market failure that prevents the usual workings of competition. It permits the rapid application of new and expensive procedures and helps insulate providers from price competition. Collective payment through insurance is a natural response to the possibility of large and uncertain health care expenses. When an insurance company or government

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program pays the bills, however, patients and health providers have less incentive to control costs carefully.

Another source of market failure is the delegation of much decisionmaking to providers. Patients who have little medical expertise are happy to benefit from whatever treatments providers recommend when the insurance will pay the bill. And even if they wish to do benefit-cost calculations, patients are often unable to judge the appropriateness, quality, or price of a health service.

Because the competitive market has failed, health spending cannot be assumed to represent well-informed demands by consumers or efficient provision of services by providers.

Many of these attributes of U.S. health markets are not unique to this country or even to the health industry. Regulatory agencies oversee other industries where competitive markets do not function, such as public utilities. In other countries, budgets, regulatory constraints, or other countervailing forces help prevent health expenditures from spiraling out of control. In this country, however, cost-containing pressures operate only on parts of the sector, and their overall impact is diluted.

## National Health Expenditures

Total spending on health is projected to reach almost $1.7 trillion in 2000, compared with about $800 billion in 1992. One can look at the projections from two points of view:

- Type of spending--hospital care, physician services, and so forth, and
- Source of funding--private or public.

### Projections by Type of Spending

Hospital, physician, drug, and nursing home expenditures accounted for almost 75 percent of national health spending in 1990 (see Summary Table 1 for CBO's baseline health spending projections classified by major type of spending).

CBO projects that hospital spending will increase at an average rate of 10 percent a year in the 1990s, up slightly from 9.5 percent in the 1980s (see Summary Table 1). The shift toward use of outpatient services is expected to continue, with the number of outpatient hospital visits increasing almost 5 percent a year. The occupancy rate for community hospitals is projected to remain below 65 percent--despite reductions in the number of available beds--as the rate of inpatient admissions per person continues to fall and the average length of a hospital stay drifts lower.

Spending on physician services is expected to increase at an average annual rate of 9.7 percent in the 1990s, down from 11.6 percent in the 1980s. Increases in physicians' charges, additional procedures per doctor visit, and the continual increase in the complexity or intensity of treatments provided in doctors' offices account for almost nine-tenths of the total increase in this spending. Changes in the demographic composition of the population and an increasing number of doctor visits per person contribute little to the growth of spending for physician services.

Spending on drugs, which is characterized by a high proportion of out-of-pocket payments, is projected to grow by about 7.5 percent a year in the 1990s. Spending on nursing home care is projected to grow 10 percent annually in the 1990s, even as financing constraints and the reluctance of states to approve new construction prevent the number of beds from keeping up with the demands of the aging population.

## Projections by Source of Funds

The main sources of funds in the health sector, accounting for more than 80 percent of total health spending, are out-of-pocket payments by patients, private health insurance payments, and Medicare and Medicaid (see Summary Table 2 for a division of national spending projections into private and government funds).

CBO projects that the number of people covered by private health insurance will increase slowly, and enrollment in the major government health insurance programs, especially Medicaid, will grow strongly. Encouraged by federal tax policy, private health insurance coverage increased steadily until the 1980s. Since the 1981-1982 recession, however, private health insurance benefits have stabilized as a share of health expenditures, and the

**Summary Table 1.**
**Projections of National Health Expenditures, by Type of Spending**

| Type of Spending | Selected Calendar Years | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1965 | 1980 | 1985 | 1990 | 1992[a] | 1995[a] | 2000[a] |
| **Billions of Dollars** | | | | | | | |
| Hospital | 14 | 102 | 168 | 256 | 310 | 416 | 671 |
| Physician | 8 | 42 | 74 | 126 | 153 | 204 | 316 |
| Drugs, Other Nondurables | 6 | 22 | 36 | 55 | 63 | 78 | 111 |
| Nursing Home | 2 | 20 | 34 | 53 | 65 | 87 | 137 |
| All Other | 12 | 64 | 110 | 177 | 218 | 287 | 444 |
| Total | 42 | 250 | 423 | 666 | 808 | 1,072 | 1,679 |
| **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | | | | | |
| Hospital | | 14.2 | 10.4 | 8.8 | 10.0 | 10.3 | 10.1 |
| Physician | | 11.5 | 12.0 | 11.2 | 10.4 | 10.0 | 9.1 |
| Drugs, Other Nondurables | | 9.0 | 10.9 | 8.6 | 7.1 | 7.5 | 7.4 |
| Nursing Home | | 17.9 | 11.3 | 9.3 | 10.5 | 10.3 | 9.5 |
| All Other | | 12.0 | 11.4 | 10.0 | 11.0 | 9.7 | 9.1 |
| National Health Expenditure | | 12.7 | 11.1 | 9.5 | 10.1 | 9.9 | 9.4 |
| **Memoranda:**[b] | | | | | | | |
| Gross Domestic Product (Billions of dollars) | 703 | 2,708 | 4,039 | 5,514 | 5,931 | 7,104 | 9,322 |
| Average Annual Growth of Gross Domestic Product (Percent) | n.a. | 9.4 | 8.3 | 6.4 | 3.7 | 6.2 | 5.6 |
| Ratio of National Health Expenditures to Gross Domestic Product | 5.9 | 9.2 | 10.5 | 12.1 | 13.6 | 15.1 | 18.0 |

SOURCE: Congressional Budget Office.

NOTES: n.a. = not applicable. Details may not add to totals because of rounding.

a. Projected.

b. Economic assumptions reflect the Congressional Budget Office baseline of January 1992.

**Summary Table 2.**
**Projections of National Health Expenditures, by Source of Funds**

| Source of Funds | 1965 | 1980 | 1985 | 1990 | 1992[a] | 1995[a] | 2000[a] |
|---|---|---|---|---|---|---|---|
| | | | **Billions of Dollars** | | | | |
| Private | 31 | 145 | 248 | 384 | 441 | 574 | 869 |
| Public | | | | | | | |
| Federal | 5 | 72 | 124 | 195 | 253 | 343 | 566 |
| State and local | 5 | 33 | 51 | 87 | 115 | 155 | 244 |
| Total, National | 42 | 250 | 423 | 666 | 808 | 1,072 | 1,679 |
| | | | **Percentage of Total** | | | | |
| Private | 75.3 | 58.0 | 58.6 | 57.6 | 54.5 | 53.5 | 51.7 |
| Public | | | | | | | |
| Federal | 11.6 | 28.8 | 29.2 | 29.3 | 31.3 | 32.0 | 33.7 |
| State and local | 13.2 | 13.3 | 12.1 | 13.1 | 14.2 | 14.5 | 14.5 |
| Total, National | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | | **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | | |
| Private | | 10.8 | 11.3 | 9.1 | 7.2 | 9.2 | 8.7 |
| Public | | | | | | | |
| Federal | | 19.7 | 11.4 | 9.6 | 13.7 | 10.7 | 10.5 |
| State and local | | 12.8 | 9.0 | 11.3 | 14.7 | 10.6 | 9.5 |
| National Health Expenditures | | 12.7 | 11.1 | 9.5 | 10.1 | 9.9 | 9.4 |
| **Memoranda:**[b] | | | | | | | |
| Gross Domestic Product (Billions of dollars) | 703 | 2,708 | 4,039 | 5,514 | 5,931 | 7,104 | 9,322 |
| Average Annual Growth of Gross Domestic Product (Percent) | n.a. | 9.4 | 8.3 | 6.4 | 3.7 | 6.2 | 5.6 |
| Ratio of National Health Expenditures to Gross Domestic Product | 5.9 | 9.2 | 10.5 | 12.1 | 13.6 | 15.1 | 18.0 |

SOURCE: Congressional Budget Office.

NOTES: n.a. = not applicable. Details may not add to totals because of rounding.

a. Projected.

b. Economic and government spending assumptions reflect the Congressional Budget Office baseline of January 1992.

continuing pressure of higher health spending is expected to cause a decrease in the proportion of people covered by private health insurance. CBO projects that the other major component of private funding--direct out-of-pocket payments by patients to providers--will continue to grow at slower rates, constrained by limited growth in patients' incomes.

CBO expects that in the 1990s private funding of health care will shrink as a share of national health expenditures. The proportion of people receiving health coverage through government programs and the share of national health spending by governments will grow.

These projections of national health expenditures incorporate CBO's January 1992 baseline for spending on the Medicare and Medicaid programs. Medicare inpatient hospital spending is expected to resume growth rates of 9 percent to 10 percent a year in the 1990s, after a period of slower growth in the 1980s. Active cost containment efforts in the 1980s temporarily reduced the growth in Medicare hospital spending, but the impact of these efforts had waned by the end of the decade. CBO assumes that the introduction of reforms in Medicare payments to physicians in 1992 will not restrain Medicare payments significantly, although payments in some physician specialties and regions of the country may be noticeably changed. Aside from physician payment reform, current law provides no major cost-containing changes during the 1990s.

CBO expects the growth of Medicaid to slow from its current rapid rate--26 percent projected for 1992 alone--to an annual rate of 12 percent by the year 2000. Medicaid remains the fastest growing source of funds for national health expenditures, and CBO projects that its share of payments will rise from 11 percent in 1990 to almost 19 percent in 2000. This increase in payments is driven by a combination of recent expansions in eligibility, rising reimbursement rates mandated by the courts, and the weakening of private health insurance coverage.

## Implications

If present laws, institutional arrangements, and trends continue in the 1990s, the high cost of private health insurance will shrink the proportion of Americans who are privately covered and increase the number of people with no insurance. Governments will pay a larger fraction of U.S. health spending through the Medicare and Medicaid programs. Higher government spending on health care has serious implications for the federal budget; the projected increase in health care spending outpaces the growth in any other major component of the budget and promises not only to preempt resources from other government programs, but also to make deficit reduction more difficult.

People pay for government health spending directly, through taxes, or indirectly, through the adverse effects of government deficit spending on capital formation and economic growth. People pay in a different sense when government health spending preempts other government expenditures, such as investments in education and infrastructure or income maintenance programs. Similarly, employees pay for employer-sponsored health insurance indirectly, through wages and salaries they might otherwise have received in the absence of coverage. The increasing cost of health benefits has contributed to the slow growth in wages and salaries that many U.S. workers have experienced in recent years. Without significant changes in public policy and private behavior, rising spending on health care will continue to limit wage and salary gains as private employers pour money into higher health insurance premiums for employees rather than into pay raises.

### Chapter Four

# Projections of National Health Expenditures by Source of Funds

The government share of health spending will increase in the 1990s under current policies and the share of private payments will decline. CBO expects strong growth in Medicare payments despite slower growth in the elderly population, and projects that Medicaid payments will continue growing rapidly because of increases in enrollments and court decisions requiring Medicaid programs to increase payments.

CBO projects that the number of people covered by private health insurance will increase slowly and the proportion of the population covered by private health insurance will continue to decrease. As a result, private health insurance benefits, which had accounted for a steadily increasing share of health expenditure until the mid-1980s, are expected to pay for a slightly smaller share of health spending by the end of the 1990s. CBO projects that the number of uninsured people will increase from about 35 million in 1992 to more than 39 million in 2000, despite the growth in Medicare and Medicaid (see Table 10).

CBO projects that direct out-of-pocket payments by patients to providers will continue declining as a share of total health spending, despite the increase in the number of uninsured people. Types of health spending that are funded largely by out-of-pocket payments tend to grow more slowly than hospital or physician spending, which are heavily insured, and many of the newly uninsured will choose to do without nonessential services and are not in a position to pay large amounts for the services they do receive. (See Figure 14 for an illustration of the share of health spending accounted for by government programs, private health insurance, and out-of-pocket payments over the 1965-2000 period.)

## Private Payments

Private health payments have been a stable percentage of health spending since the mid-1970s. Between 1975 and 1990, private health insurance payments, out-of-pocket payments, and other private payments have together accounted for about 58 percent of health expenditures. In the projections, the out-of-pocket share declines rapidly, the private health insurance share declines slightly, and the total share of private payments declines to 52 percent by the year 2000. (See Table 11 for the composition of national health expenditures, with emphasis on private sources of funds.)

### Private Health Insurance Continues to Erode

The proportion of spending on health care paid by private health insurance increased steadily during the 1970s, although its share has grown more slowly in 1980s. CBO projects that total private health insurance spending will swell from $217 billion in 1990 to $527 billion in 2000, an average annual growth

**Table 10.**
**Health Insurance Primary Coverage**

| Type of Coverage | 1980 | 1983 | 1987 | 1990 | 1992[a] | 2000[a] |
|---|---|---|---|---|---|---|
| | | | **Millions of People** | | | |
| Employer-Sponsored Insurance | 134.9 | 135.6 | 138.4 | 141.0 | 138.9 | 145.2 |
| CHAMPUS/Military | 8.8 | 9.3 | 8.9 | 8.0 | 7.7 | 6.6 |
| Individual Insurance | 19.2 | 18.6 | 16.7 | 16.9 | 16.1 | 14.8 |
| Medicare | 25.3 | 27.2 | 29.2 | 31.6 | 32.5 | 35.7 |
| Medicaid | 8.3 | 9.7 | 12.0 | 15.3 | 20.7 | 27.2 |
| Uninsured | 26.7 | 29.2 | 33.6 | 33.4 | 35.4 | 39.2 |
| Total Population | 223.2 | 229.6 | 238.8 | 246.2 | 251.3 | 268.6 |
| | | | **Percentage of Population** | | | |
| Employer-Sponsored Insurance | 60.4 | 59.1 | 58.0 | 57.3 | 55.3 | 54.0 |
| CHAMPUS/Military | 3.9 | 4.1 | 3.7 | 3.3 | 3.1 | 2.4 |
| Individual Insurance | 8.6 | 8.1 | 7.0 | 6.8 | 6.4 | 5.5 |
| Medicare | 11.3 | 11.8 | 12.2 | 12.8 | 12.9 | 13.3 |
| Medicaid | 3.7 | 4.2 | 5.0 | 6.2 | 8.3 | 10.1 |
| Uninsured | 12.0 | 12.7 | 14.1 | 13.6 | 14.1 | 14.6 |
| Total Population | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

SOURCE: Congressional Budget Office.

NOTES: CHAMPUS = Civilian Health and Medical Program of the Uniformed Services.

Estimates and projections based on data from the March Current Population Surveys. Note that the Current Population Surveys use a more restrictive definition of the population than the Social Security Administration figures used elsewhere in this report.

Details may not add to totals because of rounding.

a. Projected.

rate of 9.3 percent, slightly less than the increase in total spending on health care. Total private insurance spending in the estimates of national health expenditure equals total benefits paid to providers by private insurers plus administrative and net underwriting costs, and is identical to total health insurance premiums. Private health insurance benefits for personal health care will expand from $186 billion in 1990 to $450 billion in 2000, and administrative and net underwriting costs will remain a constant 17 percent of benefits paid (see Table 12).[1]

CBO projects that the total number of people covered by employer-sponsored insurance will grow slowly in the 1990s. Total employer-sponsored coverage increased from about 135 million people in 1980 to about 141 million in 1990 and is expected to grow to only 145 million in 2000. The number of people with individual insurance (including all insurance not organized through employ-

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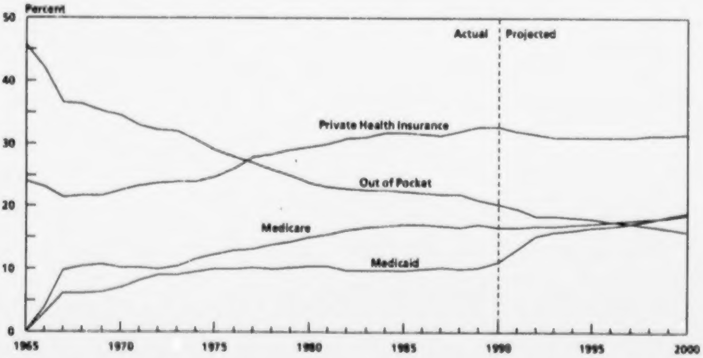
[1] This stability is caused, in part, by the fact that the private insurance underwriting cycle is not projected, as discussed in Chapter 3.

**Figure 14.**
**Major Sources of Funds for Health Care, by Percentage of Total Health Expenditures**



SOURCE: Congressional Budget Office.

ment) is expected to continue falling in the 1990s, from about 17 million in 1990 to 15 million in 2000.[2]

The rise in private health insurance benefits paid, therefore, almost entirely consists of growth in benefits paid per covered person, with the number of people covered increasing slowly. The expanding population combined with slow growth in private health insurance coverage leads to an increase in the number of uninsured people from 35 million in 1992 to 39 million in 2000, despite projected rapid increases in Medicare and Medicaid enrollment.[3]

The public often equates "health care costs" with employer-sponsored insurance premiums. It is not unusual to read that a firm faces dramatic increases in premiums to renew its current coverage. Obviously such increases represent only a portion of total health care financing, leaving out government and other private funding, and do not really represent increases in total national health costs. Moreover, premium increases quoted by particular insurance companies do not necessarily correspond to the total premium increases actually paid in the system; total premiums reported in the national health accounts frequently grow more slowly than reported increases in premium prices, as employers change coverage or offer coverage to fewer workers.

The cycle of private health insurance premiums also distorts the common view of health costs. Private health insurance premiums tend to rise rapidly as insurance companies build reserves, and then grow slowly (or even fall) until losses require new premium

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[2] For a discussion of trends in individual insurance, see Jon Gabel, "On Their Own. A Profile of the Individually Insured," *Journal of American Health Policy* (November/December 1991).

[3] Figures for insured and uninsured populations are CBO estimates based on data from the Current Population Survey and other sources.

**Table 11.**
**Projections of National Health Expenditures to 2000, by Source of Funds**

| Source of Funds | Selected Calendar Years | | | | | |
|---|---|---|---|---|---|---|
| | 1965 | 1983 | 1987 | 1990 | 1992[a] | 2000[a] |
| | | | **Billions of Dollars** | | | |
| Private | | | | | | |
| Health insurance | 10 | 111 | 155 | 217 | 254 | 527 |
| Out of pocket | 19 | 81 | 109 | 136 | 150 | 268 |
| Other | 2 | 18 | 22 | 31 | 36 | 73 |
| Subtotal | 31 | 211 | 286 | 384 | 441 | 869 |
| Public | | | | | | |
| Federal | 5 | 103 | 144 | 195 | 253 | 566 |
| State and local | 5 | 44 | 64 | 87 | 115 | 244 |
| Subtotal | 10 | 148 | 208 | 283 | 367 | 810 |
| Total | 42 | 359 | 494 | 666 | 808 | 1,679 |
| | | | **Percentage of Total** | | | |
| Private | | | | | | |
| Health insurance | 24.0 | 31.1 | 31.3 | 32.5 | 31.5 | 31.4 |
| Out of pocket | 45.7 | 22.7 | 22.0 | 20.4 | 18.6 | 16.0 |
| Other | 5.5 | 5.1 | 4.5 | 4.6 | 4.5 | 4.4 |
| Subtotal | 75.3 | 58.8 | 57.8 | 57.6 | 54.5 | 51.7 |
| Public | | | | | | |
| Federal | 11.6 | 28.8 | 29.1 | 29.3 | 31.3 | 33.7 |
| State and Local | 13.2 | 12.4 | 13.0 | 13.1 | 14.2 | 14.5 |
| Subtotal | 24.7 | 41.2 | 42.2 | 42.4 | 45.5 | 48.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | | **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | |
| Private | | | | | | |
| Health insurance | | 14.3 | 8.6 | 11.9 | 8.3 | 9.5 |
| Out of pocket | | 8.4 | 7.5 | 7.7 | 5.1 | 7.5 |
| Other | | 12.2 | 5.1 | 11.4 | 8.4 | 9.3 |
| Private health expenditures | | 11.2 | 7.9 | 10.3 | 7.2 | 8.9 |
| Public | | | | | | |
| Federal | | 18.6 | 8.7 | 10.7 | 13.7 | 10.6 |
| State and local | | 12.3 | 9.7 | 10.7 | 14.7 | 9.9 |
| Public health expenditures | | 15.9 | 9.0 | 10.7 | 14.0 | 10.4 |
| National Health Expenditures | | 12.7 | 8.3 | 10.5 | 10.1 | 9.6 |
| **Memorandum:** | | | | | | |
| Average Annual Growth of GDP (Percent) | | 9.2 | 7.5 | 6.7 | 3.7 | 5.8 |

SOURCE: Congressional Budget Office.

NOTES: Details may not add to totals because of rounding.
GDP = gross domestic product.

a. Projected.

**Table 12.**
**Private and Public Health Insurance Expenditures**

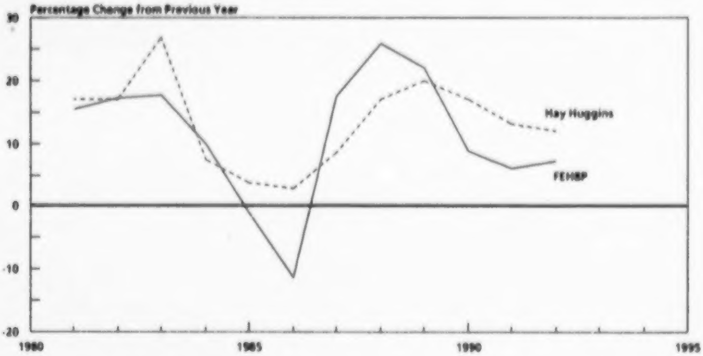
| | Selected Calendar Years | | | | | |
|---|---|---|---|---|---|---|
| | 1980 | 1983 | 1987 | 1990 | 1992[a] | 2000[a] |
| **Billions of Dollars** | | | | | | |
| Private Insurance | | | | | | |
| Benefits | 65 | 97 | 138 | 186 | 217 | 450 |
| Administration | 8 | 14 | 17 | 31 | 37 | 77 |
| Total premiums | 73 | 111 | 155 | 217 | 254 | 527 |
| Medicare | | | | | | |
| Benefits | 36 | 58 | 82 | 109 | 133 | 308 |
| Administration | 1 | 1 | 2 | 2 | 3 | 4 |
| Total expenditures | 38 | 60 | 83 | 111 | 136 | 313 |
| Medicaid | | | | | | |
| Benefits | 25 | 34 | 48 | 71 | 118 | 307 |
| Administration | 1 | 2 | 3 | 4 | 5 | 10 |
| Total expenditures | 26 | 35 | 51 | 75 | 123 | 317 |
| **Administration Rate as Percentage of Benefits Paid** | | | | | | |
| Private Insurance | 12.5 | 14.5 | 12.4 | 16.5 | 17.2 | 17.2 |
| Medicare | 3.1 | 2.4 | 2.1 | 2.1 | 2.4 | 1.4 |
| Medicaid | 5.3 | 5.2 | 5.3 | 5.4 | 3.8 | 3.4 |
| **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | | | | |
| Private Insurance | | | | | | |
| Benefits | | 14.3 | 9.1 | 10.6 | 8.0 | 9.6 |
| Administration | | 20.0 | 4.9 | 21.6 | 10.2 | 9.5 |
| Increase in premiums | | 14.9 | 8.6 | 11.9 | 8.3 | 9.6 |
| Medicare | | | | | | |
| Benefits | | 17.1 | 8.7 | 10.1 | 10.5 | 11.1 |
| Administration | | 8.3 | 4.8 | 10.0 | 17.3 | 4.2 |
| Increase in expenditures | | 16.9 | 8.6 | 10.1 | 10.6 | 11.0 |
| Medicaid | | | | | | |
| Benefits | | 10.6 | 9.5 | 13.9 | 28.8 | 12.6 |
| Administration | | 9.6 | 10.1 | 14.6 | 8.6 | 11.1 |
| Increase in expenditures | | 10.6 | 9.5 | 14.0 | 27.9 | 12.6 |

SOURCE: Congressional Budget Office.

NOTE: Details may not add to totals because of rounding.

a. Projected.

**Figure 15.**
**Trends in Private Health Insurance Premiums, 1981-1992**



SOURCE: Congressional Research Service.

NOTE: Hay Huggins surveys about 1,000 large and medium-sized employers. FEHBP is the Federal Employees Health Benefits Program, covering about 10 million people.

increases. The cycle has consistently been five or six years long, with large changes in the growth of premium prices from year to year (see Figure 15 for an illustration of the growth in premiums for the Federal Employees Health Benefits plan and the average increase reported in a private survey of large firms).[4]

## Out-of-Pocket Payments

Out-of-pocket or direct patient payments have grown much more slowly than national health spending as a whole. The proportion of national health expenditures paid directly by patients has fallen from 45 percent in 1965 (before Medicare and Medicaid) to 20 percent in 1990, and CBO projects that it will fall further to 16 percent in 2000. Direct patient payments will nevertheless rise more rapidly than gross domestic product--from 2.5 percent of GDP in 1990 to 2.9 percent in 2000--since health spending is growing faster than GDP.

Sectors with a high proportion of out-of-pocket payments--drugs, durables, and dental services--have shown slower growth in spending than sectors financed more heavily by private health insurance or government sources. Payments of deductibles and coinsurance by insured patients are considered out-of-pocket payments.

Insurance can allow patients to ignore costs when receiving treatments, but direct patient payments are subject to a stronger cost-benefit calculation. In the estimates of national health expenditures, consumer payments of private health insurance premiums (including employee cost sharing of premium payments sponsored by employers) are not classified as direct out-of-pocket payments. Instead, these payments are included in the private health insurance account, and no attempt is made to calculate the burden of private health insurance premiums on consumers. CBO assumes that consumers or workers ultimately bear the entire burden of private health insurance payments regardless of whether employers organize the coverage, or the amount of the apparent cost sharing of the premiums by employees. Thus, even if employers are asking employees to pay a greater share of their health insurance premiums, the estimates of out-of-pocket spending presented here are not affected.

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[4] Congressional Research Service, *The Federal Employees Health Benefits Program* (May 24, 1989), with updated figures from Congressional Research Service staff.

### Other Private Payments

Other private payments include hospital nonpatient revenues and philanthropy. As in the past, other private payments are expected to grow at 9.1 percent in the 1990s, maintaining about a 4.5 percent share of national health expenditures.

## Public Funding

The government's share of health care payments has been growing faster than the private share. Payments per person participating in government programs are growing at about the same rate as private health insurance benefits per covered person, but the government is becoming the primary payer for a greater proportion of the population (see Table 13 for a breakdown of the sources of funds for national health expenditures with emphasis on public funding).

### Federal

The federal share of national expenditure on health care consists of the Medicare and Medicaid programs and smaller programs supporting public health, research, and the needs of particular groups of people, such as veterans.[5] Total federal health payments are expected to rise from 29 percent of national health spending in 1990 to 34 percent in 2000.

**Medicare.** CBO projects that Medicare spending will grow at about 11 percent annually in the projection period, raising its share of national health expenditure from 17 percent in 1990 to 19 percent in 2000.

The federal Medicare program for the elderly has two parts: Hospital Insurance (HI, or Part A), which covers inpatient hospital care, and Supplementary Medical Insurance (SMI, or Part B), which covers mostly physician and outpatient hospital services. Part A is largely funded by a payroll tax. About 75 percent of Part B is funded from general revenues with the other 25 percent from premiums paid by beneficiaries.

*Medicare Part A* spending for inpatient hospital care has grown relatively slowly since the mid-1980s when the prospective payment system (PPS) was put into effect. This system pays hospitals on the basis of a fixed fee according to the broad diagnosis of the patient, or diagnosis-related group (DRG). Peer review organizations were created to help prevent inappropriate admissions of Medicare patients to hospitals. The PPS discourages hospitals from providing longer-term or maintenance care of the elderly in an inpatient setting, and admissions and lengths of stay for Medicare beneficiaries have fallen considerably since the system was started.

CBO projects that Medicare Part A inpatient hospital payments will resume growing at 9 percent to 10 percent a year in the 1990s,

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[5] Payments made by government agencies for employee health insurance are included under private health insurance payments. Government payments exclude nutrition, sanitation, and antipollution programs as these are not directly related to the provision of medical care or treatment of disease. Expenditures assisting the training of health professionals are also excluded from national health expenditures.

**Table 13.**
**Projections of National Health Expenditures in the Public Sector to 2000, by Source of Funds**

| Source of Funds | 1965 | 1983 | 1987 | 1990 | 1992a | 2000a |
|---|---|---|---|---|---|---|
| | **Billions of Dollars** | | | | | |
| Private | 31 | 211 | 286 | 384 | 441 | 869 |
| Federal | | | | | | |
| Medicare | 0 | 60 | 83 | 111 | 136 | 313 |
| Medicaid | 0 | 19 | 28 | 43 | 70 | 181 |
| Other | 5 | 24 | 33 | 41 | 46 | 73 |
| Subtotal | 5 | 103 | 144 | 195 | 253 | 566 |
| State and Local | | | | | | |
| Medicaid | 0 | 16 | 23 | 32 | 53 | 136 |
| Other | 5 | 28 | 42 | 55 | 62 | 108 |
| Subtotal | 5 | 44 | 64 | 87 | 115 | 244 |
| Total | 42 | 359 | 494 | 666 | 808 | 1,679 |
| | **Percent Distribution** | | | | | |
| Private | 75.3 | 58.8 | 57.8 | 57.6 | 54.5 | 51.7 |
| Federal | | | | | | |
| Medicare | 0.0 | 16.7 | 16.9 | 16.7 | 16.8 | 18.6 |
| Medicaid | 0.0 | 5.4 | 5.6 | 6.4 | 8.7 | 10.8 |
| Other | 11.6 | 6.7 | 6.6 | 6.2 | 5.7 | 4.3 |
| Subtotal | 11.6 | 28.8 | 29.1 | 29.3 | 31.3 | 33.7 |
| State and Local | | | | | | |
| Medicaid | 0.0 | 4.5 | 4.6 | 4.9 | 6.5 | 8.1 |
| Other | 13.2 | 7.9 | 8.4 | 8.2 | 7.7 | 6.4 |
| Subtotal | 13.2 | 12.4 | 13.0 | 13.1 | 14.2 | 14.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | | | |
| Private | | 11.2 | 7.9 | 10.3 | 7.2 | 8.9 |
| Federal | | | | | | |
| Medicare | | n.a. | 8.6 | 10.1 | 10.6 | 11.0 |
| Medicaid | | n.a. | 9.8 | 15.4 | 27.9 | 12.6 |
| Other | | 9.3 | 8.0 | 8.1 | 6.1 | 5.7 |
| All federal | | 18.6 | 8.7 | 10.7 | 13.7 | 10.6 |
| State and Local | | | | | | |
| Medicaid | | n.a. | 9.2 | 12.2 | 27.9 | 12.6 |
| Other | | 9.6 | 10.0 | 9.8 | 6.2 | 7.1 |
| All state and local | | 12.3 | 9.7 | 10.7 | 14.7 | 9.9 |
| National Health Expenditures | | 12.7 | 8.3 | 10.5 | 10.1 | 9.6 |
| **Memorandum:**<br>Average Annual Growth of GDP (Percent) | | 9.2 | 7.5 | 6.7 | 3.7 | 5.8 |

SOURCE: Congressional Budget Office.

NOTES: Details may not add to totals because of rounding.
n.a. = not applicable; GDP = gross domestic product.

a. Projected.

after a period of slower growth in the late 1980s. Inpatient admissions per enrollee are expected to resume growing, and DRG payment rates are projected to increase more quickly than in the recent past. Inpatient admissions of people over age 65 have fallen from 404 per thousand in 1983 to 350 per thousand in 1991, but CBO projects that admissions of elderly patients will grow to 374 per thousand by 2000. Since 1986, Medicare DRG payment rates have been increased more slowly than a price index (called the hospital "market basket" or "input price index") that is used to track hospital operating costs. DRG rate increases were held below this price index during portions of the 1980s, but beginning in 1995, according to current law, hospitals are scheduled to begin receiving DRG rate increases based on the full price index, which will add to Medicare costs.

*Medicare Part B* has paid for physician services in the past, based on the reasonable and customary fees for the services provided in the physician's locality. This system has been criticized for making inequitable allocations of payments between primary and specialty services, and by region.[6] For example, Medicare paid for certain intensive technological procedures and surgeries much more generously than it did for consultative visits.

Medicare began changing its method of paying physicians in 1992. The new system is based on a fee schedule with set payments for services, adjusted for differences in practice costs in different parts of the country. The fees are based on an outside determination of the relative values of each service. A feature of the new system is that the fees are expected to grow according to a price index; if overall payments grow more rapidly than a predetermined target rate in a year, the growth of fees for succeeding years may be reduced. Although the Congressional Budget Office expects some redistribution of payments among physician specialties and regions of the country, CBO projects only small reductions in total payments to physicians from the new system. Part B payments for physicians, which total about two-thirds of Part B spending, are projected to grow at about 12 percent a year during the 1990s.

The second largest component of Medicare Part B is outpatient hospital payments, which account for about 20 percent of Part B spending. CBO projects that outpatient hospital payments on behalf of Medicare beneficiaries will continue growing about 18 percent a year in the projection period. Overall Part B expenditure stabilizes at a 13 percent a year rate of growth in the 1993-2000 period.

**Medicaid.** Medicaid finances health care for some of the nation's poor and is administered by the states under broad federal guidelines. The states, which pay 43 percent of total Medicaid costs, can exercise considerable discretion in deciding whom and what to cover, and eligibility rules and coverage vary widely. Federal Medicaid spending has grown very rapidly in recent years--21 percent in 1990, 29 percent in 1991, and an estimated 26 percent in 1992. CBO projects that Medicaid growth will slow to about 12 percent a year by 2000, but Medicaid's share of national health expenditures will rise from 11 percent in 1990 to more than 19 percent in 2000.

Population and cost pressures, legislated extensions of eligibility, legal decisions requiring increased payments, and the fiscal pressures that push state and local governments to get the most funds from the federal government all drive rapid growth in Medicaid spending. In the short term, the extraordinary growth between 1990 and 1993 stems partly from so-called disproportionate share payments and tax and donation programs. Disproportionate share payments are supplementary amounts allotted to hospitals that serve unusually large numbers of indigent and uninsured patients. Legislation enacted in 1990 extended these payments and gave states great latitude to designate hospitals that qualify and placed some limits on total payments. Many states, too, have discovered a mini-bonanza in tax and donation programs since 1990. Such programs involve raising Medicaid reimbursements and simultaneously levying special taxes on providers. States have used such arrangements as a tool to obtain the highest possible federal matching payments. These complicated tactics were curtailed by Public Law 102-345, enacted in 1991, which requires that any such levies be broad-based and caps the proportion of state Medicaid spending that states can finance.

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[6] See, for example, Physician Payment Review Commission, *Annual Report to Congress* (1991), p. 1.

But even after these extraordinary growth rates taper off, longer-run pressures persist. Recent expansions in eligibility, particularly for poor children, will continue to raise the number of people who are eligible. States may keep shifting programs that they formerly funded for mental health, testing, and so forth into Medicaid to gain the federal match. Many states now run outreach programs to alert potential beneficiaries to their eligibility. The impacts of provisions for nursing home reform (enacted in 1987 but only recently effective) remain uncertain. And finally, a rash of lawsuits has resulted in sharply higher reimbursements under a 1980 amendment requiring that Medicaid payments to providers be "reasonable and adequate." Pressures for increased Medicaid payments will continue to inflate the costs of the program.

**Other Federal Funding**. The Department of Defense, the Department of Veterans Affairs (VA), and the National Institutes of Health spend most of the rest of federal health funds, which CBO expects will grow at about the same rate as GDP in the projection period, from $41 billion in 1990 to $73 billion in 2000. CBO projects that slow growth in VA hospital spending and declines in health insurance enrollment through the Department of Defense will help restrain the total cost.

## State and Local Government Financing

CBO projects that total state and local funding for health will grow at double-digit rates through the mid-1990s, before tapering off to about 9 percent a year in 2000. These growth rates are considerably higher than the growth expected in state and local revenues outside of federal Medicaid payments. Under current policies, therefore, unless taxes are increased, states are likely to have very little room to expand nonhealth spending.

**Medicaid**. CBO assumes that Medicaid costs at the state and local level will grow at the same rate as federal payments, and expects that the current ratio of state and local Medicaid funding to federal--43 percent to 57 percent--will remain constant. States' efforts to increase the effective federal matching rate through tax and donation schemes are not expected to result in any further increase in the federal share.

**Other State and Local Health Payments**. Other expenditures by state and local governments for health care include workers' compensation, direct support of public hospitals and school health programs, and public health efforts. CBO projects that state and local spending other than Medicaid will grow less rapidly than national health expenditures as a whole. The other state and local share of national health expenditures thus declines from 8.2 percent in 1990 to 6.4 percent in 2000. Despite the declining share of total spending on health, other state and local spending is expected to grow more rapidly than GDP, averaging 7 percent growth a year in the 1990s compared with 5.4 percent average annual growth in GDP.

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CRS Report for Congress
Congressional Research Service • The Library of Congress

# HEALTH CARE FACT SHEET: 1991 NATIONAL HEALTH SPENDING

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## NATIONAL HEALTH EXPENDITURES, 1991

In 1991, national health spending totalled $751.7 billion and accounted for 13.2 percent of the Gross Domestic Product (GDP). The Nation's health spending increased by 11.4 percent between 1990 and 1991. This marks the fourth consecutive year of double digit growth. Since 1988 health spending had grown from 10.9 percent of GDP to its current level of 13.2 percent. Recent projections by the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO) indicate that the Nation's health bill may equal 18 percent of GDP by 2000.

## HEALTH CARE SERVICES

In 1991, 88 percent of all health spending ($660 billion) was for personal health care--services used to treat or prevent disease in individuals. The remaining 12 percent ($92 billion) was spent on health program administration; administrative costs and profits earned by private health insurers; noncommercial health research, such as Federal funding for the National Institutes of Health; new construction of health facilities and government public health activities.

Four major service categories accounted for most of health spending: hospital services, physician services, drugs and other nondurable medical supplies, and nursing home care. These four categories accounted for 73 percent of total spending. Table 1 displays national health spending by major spending category.

## SOURCES OF PAYMENT FOR HEALTH SPENDING

Private spending amounted to 56 percent of all health spending, with private health insurance and individuals' out-of-pocket payments accounting for almost all of this share. Government spending represented the remaining 44 percent, with the Federal Government paying for 30 percent of the total and State and local governments paying 14 percent. Medicare and Medicaid spending accounted for two-thirds of total government health spending. Table 2 displays national health spending by major payer.

*CRS Reports are prepared for Members and committees of Congress*

**TABLE 1. National Health Spending by Major Spending Category, 1991**
(spending in millions of $)

| Spending category | CY 1991 spending | Percent of total |
|---|---|---|
| **Personal health care** | $660,217 | 87.8% |
| Hospital services | 288,627 | 38.4% |
| Physician services | 141,985 | 18.9% |
| Drugs and other nondurables | 60,674 | 8.1% |
| Nursing home care | 59,943 | 8.0% |
| Dentists' services | 37,066 | 4.9% |
| Other professional services | 35,823 | 4.8% |
| Other personal health care | 13,976 | 1.9% |
| Vision products and other medical durables | 12,361 | 1.6% |
| Home health care | 9,762 | 1.3% |
| **Related spending** | 91,554 | 12.2% |
| Program administration & net cost of private health insurance | 43,880 | 5.8% |
| Public health activities | 24,533 | 3.3% |
| Research and construction | 23,141 | 3.1% |
| Total | $751,771 | 100.0% |

**Source:** Table prepared by the Congressional Research Service based on data from HCFA, Office of the Actuary.

**TABLE 2. National Health Spending by Payer, 1991**
(Payment amounts in millions of $)

| Source of payment | Payment amount | Percent of total |
|---|---|---|
| **Total public** | $329,960 | 43.9% |
| Federal spending | 222,873 | 29.6% |
| Medicare | 122,803 | 16.3% |
| Medicaid | 55,873 | 7.4% |
| Other Federal | 44,197 | 5.9% |
| State and local spending | 107,086 | 14.2% |
| Medicaid | 44,641 | 5.9% |
| Other State and local | 62,445 | 8.3% |
| **Total Private** | 421,811 | 56.1% |
| Private health insurance | 244,367 | 32.5% |
| Out-of-pocket | 144,260 | 19.2% |
| Other private | 33,184 | 4.4% |
| Total | $751,771 | 100.0% |

**Source:** Table prepared by the Congressional Research Service based on data from HCFA, Office of the Actuary.

90-64 EPW

# CRS Report for Congress

## Controlling Health Care Costs

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January 26, 1990

CRS

Congressional Research Service • The Library of Congress

# CONTROLLING HEALTH CARE COSTS

## SUMMARY

Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. There are concerns that continued growth in health care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. While efforts to control medical spending have been a central issue in health policy at least since the early 1970s, these concerns have given the issue a new urgency.

Most proposals to limit health care spending have relied on one of four basic approaches. The first is to change the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care. Increases in required deductible and coinsurance payments by enrollees in health plans can reduce overall costs. However, they may have a disproportionate impact on low-income persons, deterring even necessary care, and may not affect the treatment decisions of providers, who control much of total health spending.

The second major approach is to change provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources. Insurers have had some success in controlling inpatient hospital services through external review systems, but savings have been largely offset by a growth in outpatient services. These have proved harder to manage, in part because there is little agreement about what constitutes appropriate care. There are hopes that further research on the effectiveness of medical treatments can provide a basis for limiting unnecessary care. If reductions in utilization are to achieve their full savings potential, however, they may need to be accompanied by controls on the overall supply of medical resources. Supply controls through local health planning systems were attempted in the 1970s, but encountered political barriers and had limited success.

The third cost control approach is to change provider behavior through reimbursement systems that provide incentives for greater efficiency. Several States, as well as Canada and other nations, have adopted payment systems that fix in advance the resources a provider can consume in treating an individual patient or an entire patient population. These systems may encourage more cost-effective treatment, but may also delay the introduction of new medical technologies or otherwise compromise quality. Their long-term potential for cost savings may rest on the willingness of the public to accept trade-offs between cost and other priorities.

The last major approach is to encourage consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems. Health maintenance organizations (HMOs) and other managed care systems have shown some ability to control costs, using utilization controls, financial incentives for providers, and other methods. The ability of these programs to achieve their full savings potential may be limited by the reluctance of higher-cost patients to accept the restrictions on choice of providers imposed by HMOs.

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# CONTROLLING HEALTH CARE COSTS

## INTRODUCTION

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other industrialized nation. U.S. health expenditures in 1987 reached $500 billion, 11.1 percent of GDP, as compared to 8.6 percent in Canada, 6.8 percent in Japan, and 6.1 percent in the United Kingdom.[1] Despite its higher expenditures, the United States performs no better than other industrialized nations, and worse than many, on such measures of health care outcomes as life expectancy or infant mortality rates. These international comparisons have led many observers to conclude that our medical care system is much less efficient than those elsewhere, spending more for less.

Not everyone would agree. Gross measures of health status may reflect, not the relative efficiency of our medical care system, but other differences between the United States and other countries. Life expectancy, for example, may be tied to diet or environment, while infant mortality rates may in part reflect such factors as the rate of teenage pregnancy. Other aspects of quality may not be captured by these measures at all. For example, Americans (or at least insured Americans) may have greater access to advances in medical technology than persons in other countries or may be less likely to have to wait for non-emergency treatment. Assessing the efficiency of the American system depends in part on how one defines quality, a problem that will be considered further at the end of this report.

Whatever the relative quality of American medical care, there are concerns about the rate at which health expenditures are increasing. Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. National health expenditures rose an average of 13 percent a year from 1970 through 1981. The rate of growth declined over the next several years, chiefly because of a decline in inpatient hospital admissions. Between 1984 and 1985 total costs rose just 7.9 percent, the lowest annual rate of increase since the enactment of Medicare and Medicaid in 1965 (though still greater than the growth in GDP). This moderation in expenditure growth proved short-lived. Costs rose 9.8 percent in 1987, and employers and insurers have reported dramatic cost increases over the next

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[1] Schieber, George J., and Jean-Pierre Poullier. International Health Care Expenditure Trends: 1987. *Health Affairs*, v. 8, no. 3, fall 1989. p. 169-177. (Hereafter cited as International Health Care Expenditure Trends: 1987.)

2 years. For example, one recent survey has found that employers' average cost per employee for health benefits rose 19 percent in 1988.[2]

The return of double-digit medical care inflation after a temporary respite has led to concerns that continued growth in medical care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. Many employers have already reduced their contribution to employees' insurance expenses, while the costs of public insurance programs are consuming an increasing share of State and Federal budgets. Proposals to extend coverage to the uninsured have raised concerns that any expansion of the insured population might lend a further impetus to medical care inflation, as did the enactment of Medicare and Medicaid in 1965. While the issue of health care costs and ways of controlling them has been a central one in health policy at least since the early 1970s, these recent developments have given the issue a new urgency.

This report examines policy options for controlling the increase in health care costs by modifying the way medical care is delivered or financed. Most proposals have relied on one of four basic approaches:

- Changing the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care;
- Changing provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources;
- Changing provider behavior through reimbursement systems that provide incentives for greater efficiency;
- Changing the behavior of both providers and consumers by encouraging consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems.

The remainder of this report provides an overview of the concepts underlying these basic approaches and the evidence available about their ability to achieve savings and their potential impact on access and quality of care. The greatest attention is devoted to the last of the four strategies, competition, because this approach has dominated policy discussion in recent years.

The report does not consider changes outside the health care delivery system that could directly or indirectly affect medical care expenditures. For example, the incidence of illness or injury might be reduced through public health or health education measures, stronger environmental controls, or improved safety regulation. Changes in the civil litigation system (i.e., malpractice reform) could reduce the practice of "defensive medicine" that is alleged to result in the performance of unnecessary tests or procedures. Such measures might well play an important role in any comprehensive initiative to control medical care spending. They are omitted in order to allow this report to focus more directly on the medical care system itself and on proposals to change the way consumers and providers behave within that system.

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[2] Geisel, Jerry. Health Benefit Tab Rises 19% to New High. *Business Insurance*, Dec. 11, 1989. p. 1.

## COST SHARING

Proposals to hold consumers responsible for more of the costs of their own medical care begin with the premise that comprehensive insurance coverage, largely funded by employers or government, has distorted the health care market by freeing consumers of any need to consider the utility or price of the services they are consuming. While not all observers share the view that growth in health care costs is driven by consumer choices, there are increasing calls for measures to encourage consumers to become more conscious of the price and utility of the medical services they use.

There are two broad ways of doing so. The first is to require consumers to pay a higher share of the premiums for their health care coverage, thus giving them an incentive to choose the most efficiently operated plan. This approach is the subject of the final section of this memorandum. The second method, considered in this section, is to make consumers pay more of the direct costs of the services they use by increasing the deductibles or coinsurance payments required under their insurance plans.

Increases in enrollee cost-sharing responsibility can reduce overall medical expenditures only if they deter some enrollees from obtaining care. Otherwise, they merely shift expenses from the insurer to the consumer.[3] The major study of the impact of cost-sharing on health care utilization and costs was the Health Insurance Experiment (HIE) conducted between 1974 and 1982 by the RAND Corporation, under contract to the Health Care Financing Administration. The HIE randomly assigned 7,700 enrollees to a variety of health insurance plans, including a plan that included no cost-sharing (the "free" plan) and plans requiring coinsurance payments ranging from 25 to 95 percent (subject to overall limits on out-of-pocket expenditures).

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[3] Deductibles have other behavioral effects that may also produce cost savings. Enrollees whose costs during a year exceed the deductible by only a small margin may not go to the trouble of filing a claim. Other enrollees who are careless in record-keeping may be unable to document all of their out-of-pocket expenditures and may therefore spend more than the nominal deductible before the insurance takes over.

The key findings of the HIE were these:[4]

- Cost-sharing reduced the probability that individuals would seek care for any particular medical condition. The strongest deterrent effects occurred among the poor, especially poor children. They were at least 40 percent less likely to obtain care for a given condition than children in the free plan.

- Cost-sharing deterred enrollees from obtaining both "appropriate" and "inappropriate" medical care. Low-income enrollees in the cost-sharing plans were less likely to seek care for conditions for which medical care is highly effective, as well as for conditions for which medical care is rarely effective. Those in the cost-sharing plans had worse outcomes for specific conditions (such as hypertension) that can be improved by medical treatment.

- While cost-sharing prevented enrollees from initiating an episode of medical care, it did not change the course of treatment once an individual had entered the medical care system. Within any given episode of care, the cost-sharing enrollees received the same services and medications as other patients.

These findings raise several important concerns about the utility of cost-sharing as an approach for reducing medical expenditures. First, as would be expected, its impact is greatest on enrollees with the least income. This effect might be modified by developing cost-sharing requirements that varied by income. Such a system might be administratively cumbersome for employers or insurers. It might also defeat its own purpose, since cost-sharing may not reduce utilization unless it is financially burdensome. (The HIE enrollees in the least burdensome cost-sharing plan actually incurred slightly higher costs than those in the free plan.)

Second, cost-sharing may deter necessary as well as unnecessary care. The goal of making consumers more prudent in their use of health services may demand a degree of sophistication about the value of different services that not all enrollees possess. There have been attempts to develop more carefully targeted cost-sharing systems, to control only inappropriate utilization or to channel utilization in particular ways. For example, a higher coinsurance amount may be imposed for emergency room visits, in order to prevent enrollees from using the emergency room for non-urgent care; this approach is common in health maintenance organizations (HMOs) and has been adopted by some State Medicaid plans. It is not certain, however, that even such narrower measures will deter only unnecessary care.

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[4] This summary is drawn from Lohr, Kathleen, et al. Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial. *Medical Care*, v. 24, no. 9, (Supplement) Sept. 1986. p. S74-S77; and Brook, Robert H., et al. Does Free Care Improve Adults' Health?: Results From a Randomized Controlled Trial. *New England Journal of Medicine*, v. 309, no. 23, Dec. 8, 1983. p. 1426-34.

Finally, and perhaps most important from the perspective of cost reduction, cost-sharing may not modify the course of care once treatment has begun, presumably because the decision-making has generally shifted from the patient to the physician. This finding of the HIE is partly a result of the design of the experiment. Regardless of the level of cost-sharing required, each plan had an out-of-pocket limit, a point beyond which the insurer assumed full responsibility for all further expenses. In the absence of such a limit, enrollees might have been more likely to decline the services ordered by their physicians. At the same time, however, the most severely ill would have been subject to catastrophic financial losses.

Most medical care costs are incurred by a small minority of patients.[5] A cost-sharing system without catastrophic limits will leave that minority unprotected, while a system with limits on out-of-pocket expenses may have a minimal effect on the total costs of care once treatment has been initiated. The problem of controlling the costs of ongoing treatment is the subject of the next section.

## CHANGING MEDICAL PRACTICE

Because most medical care purchasing decisions are made by physicians and other providers, rather than by the patients themselves, savings might be achieved if unnecessary services could be eliminated through external review of those decisions or through efforts to modify the providers' own decision-making.

### External Utilization Controls

The term "utilization controls" embraces a variety of external constraints imposed by a payer on the volume or nature of services furnished or ordered by providers.[6] These include:

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[5] In 1978, 10 percent of U.S. families accounted for 67 percent of total health expenditures. U.S. Congress. Congressional Budget Office. *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population*. Washingtc [illegible] U.S. Govt. Print. Off., De[illegible] 1982. p. xviii.

[6] These techniques [illegible] sometimes referred to [illegible]y health insurers as "managed care." Oth[illegible]strict the term "managed care" to the more aggressive interventior [illegible]he health care system represented by HMOs or similar entities. This i[illegible] sense in which the term will be used later in this report.

- Pre-admission certification for elective inpatient stays;

- Concurrent review, under which patients already admitted to the hospital are monitored to ensure the appropriateness of their continued stay;

- Voluntary or mandatory second opinions before elective surgery;

- Case management, under which the payer or the payer's agent attempts to assume control of the overall delivery of services to an individual high-cost patient;

- Various approaches for shifting the locus of care from high-cost to low-cost settings. These include requirements that certain surgical procedures be performed on an outpatient basis, or that diagnostic tests ordinarily required for inpatients be conducted before the patient is admitted to the hospital.

Utilization controls, especially pre-admission certification and concurrent review, have become a standard feature of health insurance plans during the 1980s. They are now used in the Medicare program, in 29 State Medicaid programs (as of 1987), and in 72 percent of employer-sponsored health plans (as of 1988), up from 59 percent just a year earlier.[7] Despite the rapid adoption of utilization control systems by both public and private payers, they have received little systematic study, and evidence that they actually reduce spending is limited. Pre-admission review has the strongest track record; one controlled study found that it produced net savings for an average employee group of 7.3 percent, with even higher savings for groups that had very high utilization before the programs were initiated.[8] The evidence on some of the other approaches is less clear. For example, some studies have suggested that voluntary second surgical opinion programs may not deter enough unnecessary surgery to offset the costs of the second opinions themselves; mandatory programs appear to be more successful.[9]

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[7] Lindsey, Phoebe A. Medicaid Utilization Control Programs: Results of a 1987 Study. *Health Care Financing Review*, v. 10, no. 4, summer 1989.

p. 79-92; and Gabel, Jon, et al. Employer-Sponsored Health Insurance in America. *Health Affairs*, v. 8, no. 2, summer 1989. p. 116-128.

[8] Feldstein, Paul, Thomas Wickizer, and John Wheeler. Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures. *New England Journal of Medicine*, v. 318, no. 20, May 19, 1988. p. 1310-14.

[9] For a review of the literature, see Ermann, Danny. Hospital Utilization Review: Past Experience, Future Directions. *Journal of Health Politics, Policy and Law*, v. 13, no. 4, winter 1988. p. 683-704.

There are also concerns that even the most successful utilization control approaches focus only on inpatient care and may merely shift the site in which care is delivered without fundamentally changing medical practice.[10] If a reduction in inpatient admissions is followed by an increase in outpatient services, savings may be only temporary; soon costs may begin to rise again as rapidly as before. One observer has argued that, because technologies that were once available only in hospitals are now widely diffused in the community, the hospital is no longer the appropriate focus of cost-containment efforts. At the same time, however, utilization controls for ambulatory services have been slow to develop. In part, this is because most ambulatory services have relatively small prices. The administrative costs of reviewing each service may outweigh any potential savings.[11] Some insurers have begun to require prior authorization for the most costly outpatient services, such as CAT scans or other major diagnostic procedures. Whether such measures are actually producing savings is not yet known.

Utilization controls face another barrier that may be even more important than administrative costs: the subjective nature of medical practice. Each patient is somehow unique, and external reviewers may have difficulty overriding the clinical judgments of individual practitioners in specific cases. This may be especially true when there is little consensus about the most appropriate treatment for a given condition, a problem to be discussed in the next section. In any event, some observers have contended that a persistent physician who is prepared to appeal a denial of authorization will often prevail. (The relative leverage of the individual practitioner may have been enhanced by recent legal decisions subjecting external utilization control agents to malpractice liability for denials of necessary care.) In consequence, utilization review may function as a delaying tactic rather than an absolute control, achieving savings only because some physicians will not take the trouble to protest the reviewers' decisions. The result has been termed "rationing by inconvenience."[12] Such savings as are achieved may diminish over time as physicians become more skillful in dealing with the system.

For this reason, some analysts have suggested that savings over a longer term may depend on the extent to which providers "sign on" to the concept of eliminating unnecessary services. In this view, real utilization control will require voluntary changes in the way physicians practice medicine.

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[10] For a discussion of this issue, see *Institute of Medicine*. Controlling Costs and Changing Patient Care? The Role of Utilization Management. Washington, 1989.

[11] Goldsmi Jeff C. Competition's Impact: A Report from the Front. *Health Affairs*, v. 7, no. 3, summer 1988. p. 162-173.

[12] Grumet, Gerald W. Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon. *New England Journal of Medicine*, v. 321, no. 9, Aug. 31, 1989. p. 607-11.

## Modifying Practice Styles

Beginning in the 1970s, studies by Wennberg and others showed that there was substantial geographic variation in the rate of use of specifi medical or surgical procedures. For example, the rate of tonsillectomies in one area of New England was six times higher than the lowest rate in the region.[13] While some of the variations uncovered in "small area analysis" might be attributable to differences in the incidence of illness in different populations, this explanation appeared to be insufficient to account for all the variation; some other factors had to be at work. One hypothesis was that physicians in different areas had different "practice styles." Each community had its own medical culture, its own characteristic way of diagnosing or treating particular diseases or conditions. Physicians adopted the practice style of their community in the absence of firm and objective information about which treatment approach was actually superior.

Other explanations have been offered for small area variations in medical practice; these will be discussed further below. However, the practice style hypothesis has won many supporters and has led to proposals for controlling medical care costs by (a) improving knowledge of the relative efficacy of different medical treatments and (b) disseminating this knowledge to practitioners in the expectation that they will modify their practice styles accordingly. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) establishes a new program within the Department of Health and Human Services for research on the effectiveness of medical treatments and the development of practice guidelines. Not all of the proponents of this initiative view it as a cost-containment measure. Some view it chiefly as a possible way of improving quality of care, and therefore worth pursuing whether or not any cost savings result. The following discussion, however, considers only the potential of medical practice research to reduce costs.

To have a significant impact, guidelines will need to address areas of practice on which there is real disagreement among physicians. There have been some efforts in the past to codify elements of medical practice on which there already existed a consensus. However, if most physicians already agree on the best treatments, promulgating that agreement in the form of guidelines may not have a measurable impact on medical practice. (This appears to have been the case, for example, with a 1984 consensus report on the treatment of high blood pressure.[14]) For this reason, the treatment research initiative will focus on conditions for which there is found to be a wide variation in current practice. Because the Nation is just beginning to devote significant resources to research on the outcomes of alternative medical treatments, it may take time for researchers to reach agreement in cases where practice variation is the result of real scientific uncertainty. The full potential savings from this strategy might therefore be realized only over the long term.

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[13] Wennberg, John, and Alan Gittelsohn. Variations in Medical Care Among Small Areas. *Scientific American*, v. 246, Apr. 1982. p. 120-134.

Assuming that future research can resolve disagreements over appropriate treatments, there would remain the task of inducing physicians to modify their practices voluntarily on the basis of the new findings. Some success in changing practices has been reported when physicians have been introduced to guidelines through structured face-to-face educational programs conducted by respected peers.[15] Some other efforts that relied only on printed materials to communicate practice recommendations have had disappointing results. Providers could be aware of and even approve the recommendations without making significant changes in practice. It is possible that some physicians may encounter barriers in implementing even guidelines with which they nominally agree. These may include concerns about malpractice liability, lack of the substitute skills or the special equipment needed to follow the guidelines, economic incentives, or pressure from patients.[16] These barriers might be overcome with more vigorous educational efforts. Still, countervailing economic and professional pressures may limit the willingness or ability of physicians to comply voluntarily with treatment guidelines.

One alternative is to use the results of outcomes research as the basis for mandatory, rather than voluntary, guidelines--that is, as a way of strengthening or broadening current utilization control programs. Proposals to do so have met strong opposition from the medical community, on the grounds that medicine cannot be reduced to a "cookbook" and that to compel physicians to comply with fixed practice rules would stifle innovation. In addition, there would remain the problem of achieving sufficient savings to offset the administrative costs of review systems.

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[14] Hill, Martha N., David M. Levine, and Paul K. Whelton. Awareness, Use, and Impact of the 1984 Joint National Committee Consensus Report on High Blood Pressure. *American Journal of Public Health*, v. 78, no. 9, Sept. 1988. p. 1190-94.

[15] See Chassin, Mark R. Standards of Care in Medicine. *Inquiry*, v. 25, no. 4, winter 1988. p. 437-453.

[16] Lomas, Jonathan, et al. Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians. *New England Journal of Medicine*, v. 321, no. 19, Nov. 9, 1989. p. 1306-11; and Kosecoff, Jacqueline, et al. Effects of the National Institutes of Health Consensus Development Program on Physician Practice. *Journal of the American Medical Association*, v. 258, no. 19, Nov. 20, 1987. p. 2708-13.

Another option is to replace service-by-service utilization review with general comparisons of each physician's practice patterns to those of his or her peers. Physicians who, over time, consistently furnished or ordered more of certain services than others in the peer group would be targeted for closer scrutiny, to determine whether patterns of inappropriate utilization existed. Physicians found to be outliers might be the focus of special educational efforts in the hopes of inducing voluntary change. Continued noncompliance might trigger requirements that individual services receive prior authorization or could even lead to exclusion from participation in a given public or private insurance program.

How much could be saved if all inappropriate services were eliminated? Some studies have found very high rates of unnecessary care. For example, Chassin et al., in a thirteen-site study, found that 17 percent of all coronary angiographies were unnecessary; for other procedures, the rate of inappropriate use was as high as 32 percent. They also found, however, that the unnecessary care explained only a small fraction of variations in utilization across geographic areas. If none of the inappropriate angiographies had been performed, the area with the highest use of this procedure would still have had more than twice the number of angiographies as the lowest-use area. The authors suggest that other factors must play a part in this difference: disease incidence, differences in the point at which primary care physicians decide to refer patients to specialists, or cultural or social differences in the stage at which patients sought care.[17] Another multi-site study has found that, while practice style may explain differences in utilization of certain specific procedures, it does not explain overall differences in per capita use of medical care in different areas. At the aggregate level, standard socioeconomic factors could explain much of the difference in use and intensity of services.[18]

These preliminary studies suggest that there could be underutilization of services in some areas, while there is overutilization of the same services in other areas. Treatment research could pinpoint, not only cases in which unnecessary services could be eliminated, but also cases in which patients have had insufficient access (whether physical or financial) to necessary care. It is for this reason that some proponents of outcomes research have emphasized its potential impact on quality, rather than its potential for cost

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[17] Chassin, Mark R., et al. Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? *Journal of the American Medical Association*, v. 258, no. 18, Nov. 13, 1987. p. 2533-2537.

[18] Folland, Sherman, and Milan Stano. Sources of Small Area Variations in the Use of Medical Care. *Journal of Health Economics*, v. 8, no. 1, Mar. 1989. p. 85-107.

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savings. Precisely because there is uncertainty about the relative efficacy of many treatments, it may be too early to say whether optimal medical treatment would involve more or fewer services than are currently furnished.

## SUPPLY CONTROLS

If utilization controls or practice guidelines succeed in limiting unnecessary care, the full potential savings from any reduction in the number of services delivered may be realized only if there is a proportionate reduction in the resources used to provide those services. For example, changes in medical practice in the late 1970s and early 1980s led to a decline in inpatient hospital admissions without a corresponding reduction in hospital capacity. The result in many areas has been underutilized facilities spreading their fixed costs across a declining number of patients; while there are fewer patients, the cost for each patient rises because the unused capacity must still be paid for.

In addition, the existence of excess capacity may generate continuing pressures to find some new way of using that capacity and restoring utilization to its previous levels.[19] The view that the use of medical services could rise to fill any underused resources led to what was perhaps the dominant approach to cost containment in the 1970s: health planning, the regulation of facility construction and other capital expenditures.

In 1964, New York became the first State to establish a certificate-of-need (CON) program, under which proposals to build a new facility or expand an existing one had to be approved by a government agency. Other States followed, and a 1972 amendment to the Social Security Act provided that facilities in those States proceeding with construction without obtaining a CON could be denied Medicare and Medicaid reimbursement for their capital expenditures. Finally, the Health Planning and Resources Development Act in 1974 required all States to establish similar programs. This requirement was repealed in 1986, along with all Federal support for State health planning programs. States may continue to operate programs on their own; 39 States and the District of Columbia still do so. However, Medicare reimbursement is no longer contingent on State approval of capital

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[19] The view that hospital admissions rise in proportion to hospital bed capacity was originally advanced by Milton Roemer, in Bed Supply and Hospital Utilization: A Natural Experiment. *Hospitals*, v. 35, no. 21, Nov. 1, 1961. p. 36-42; Some more recent studies have concluded that the relation between supply and utilization may not be as straightforward as "Roemer's law" would suggest. Brewer, W. Ross, and Mary Ann Freedman. Causes and Implications of Variation in Hospital Utilization. *Journal of Public Health Policy*, v. 3, no. 4, Dec. 1982. p. 445-454.

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expenditures, and a number of States have now limited their reviews to nursing home construction.[20]

Several factors contributed to the reversal of policy on health planning. In part, it fell victim to the general preference for market as opposed to regulatory solutions during the early 1980s. From a Federal perspective, the adoption in 1983 of Medicare's prospective payment system (PPS) for inpatient hospital services was expected to offer a different way of limiting health care resources; this approach is discussed further in the next section.[21] Underlying this shift, however, were claims that health planning had been tried and had failed, largely because of conflicting political pressures. In many areas, the oversupply of facilities was such that savings would have required, not just limits on new construction, but closure or consolidation of existing facilities. Few States were able to overcome the political resistance to such closures. Attempts to limit duplication of services or the spread of new technologies often faced similar barriers; attempts to plan for the rational distribution of resources on a regional basis had to confront providers' fears of losing to competitors and individual communities' desires for the most up-to-date facilities.[22]

CON programs did have some successes, particularly in constraining the growth in nursing home beds. Because State Medicaid programs are the major source of payment for nursing home care, States had a strong motive to overcome the political barriers to supply constraint. In at least some States, the CON process was explicitly seen as a Medicaid cost-containment measure; the determination of the number of nursing home beds needed was related to the maximum number of patients the State was prepared to cover.[23] Even in this case, however, any savings were achieved by holding growth in bed supply below the rate of growth in the aged population. States generally did not close down existing capacity.

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[20] American Hospital Association. State Issues Forum. *State Health Planning Report*. Chicago, July 1989.

[21] The inclusion of capital expenditures in PPS payments has been repeatedly postponed. Hospitals are instead paid for Medicare capital expenses on a reasonable cost basis, subject to a fixed percentage discount (15 percent beginning Jan. 1, 1990).

[22] For an overview of the barriers to health planning, see Brown, Lawrence D. Common Sense Meets Implementation: Certificate-of-Need Regulation in the States. *Journal of Health Politics, Policy and Law*, v. 8, no. 3, fall 1983. p. 480-494. (Hereafter cited as Common Sense Meets Implementation.)

[23] Feder, Judith, and William Scanlon. Regulating the Bed Supply in Nursing Homes. *Milbank Quarterly*, v. 58, no. 1, 1980. p. 54-88.

Recent concern about the rate of medical care cost increases has led to some calls for a revival of health planning, and it is conceivable that these concerns might eventually be sufficient to overcome the political barriers faced by health planners in the past. However, not all of the problems with health planning are political ones. Effective planning may require a fuller understanding of the workings of the health care system than is currently available. That system is a dynamic one, and decisions that seemed sensible in the late 1970s have sometimes had unpredictable effects. For example, most planning programs focussed on institutional services in hospitals and nursing homes, because these were the major sources of expenditure, and did little to control the capital expenditures of community-based physicians or clinics. The resulting growth in the availability of high-technology facilities outside hospitals is one of the reasons that recent reductions in inpatient utilization have been offset by increased outpatient costs. (Some States are now applying uniform rules across settings.)

Moreover, a community's needs may change unpredictably. New York was more successful than most States in controlling inpatient bed supply; it was one of the few States in which hospital closures occurred on a planned basis. While the number of community hospital beds nationally dropped 1.1 percent between 1977 and 1987, the number in New York dropped 9.9 percent.[24] New demands on these facilities in the 1980s, such as the appearance of AIDS (acquired immune deficiency syndrome) and the rise in drug-related problems, have led to serious overcrowding in some New York hospitals. The reported crisis in New York illustrates one of the potential constraints on the planning process. On the one hand, it may be necessary to maintain enough excess capacity to meet unforeseen needs or random fluctuations in demand. On the other hand, this excess capacity is costly to maintain and may itself generate demand. If the supply of a given kind of service is sufficient that no one ever has to stand in line for it, then the savings from health planning may be limited.

The fullest potential savings from health planning would require a more controversial step: limiting the supply of health resources to the point at which patients may have to wait for some period to obtain needed but non-emergency services. The result is "queueing," the delays in surgery or high-cost diagnostic procedures that are alleged to occur to some extent in Canada and to a greater extent in the United Kingdom. The degree to which queueing actually occurs in either country's health system has often been debated by those who favor or oppose adoption of a similar system here. Some people say that essential care may be unavailable, while others argue that resource limits merely oblige providers to set priorities and avoid unnecessary services.

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[24] American Hospital Association. *Hospital Statistics*, 1978 and 1988 editions.

Whatever the extent to which resources have been limited elsewhere, rationing of supply in the United States might raise concerns that are not as significant in countries where the entire population participates in a single insurance program. In those countries, everyone is in the same queue, and one's place in line is chiefly determined by the urgency or duration of one's need. (There are exceptions: one can step out of line in the United Kingdom by finding a private provider, and there are anecdotal accounts that some Canadians with sufficient resources may seek care in the United States.) When queueing has occurred in the United States, however, places in line may have been determined by financial resources.

The facilities in New York reporting the greatest overcrowding have been those serving the poor and the uninsured. Similar effects may have resulted from health planning's major success, the control of nursing home bed supply. Because Medicaid payment is generally less than that available from private patients, nursing homes in areas with limited bed supply and high occupancy rates have an incentive to accept a private-pay patient when a vacancy occurs, while Medicaid beneficiaries may be unable to find a place. In 28 States, Medicaid administrators report that beneficiaries awaiting hospital discharge had difficulty finding a nursing home bed.[25] While supply constraints are not the only factors limiting access to care for low-income Americans, they may exacerbate existing problems. The acceptability of health planning as a cost control strategy may, then, depend in part on the extent to which supply limitations are accompanied by efforts to make distribution of limited resources more equitable.

One other issue should be raised in the context of a discussion of health resources: the debate over the possible oversupply of physicians and the potential consequences of physician supply on health care costs. In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) reported that the United States would have a surplus of 150,000 physicians by the year 2000.[26] The extent of the potential surplus has since been the subject of continuing debate. There are questions about the extent to which technology and the aging of the population could increase demand, or the adoption of utilization controls or managed care could decrease it. The number of medical school admissions could decline, or physicians might spend more of their time on administrative activities and less on patient care.[27]

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[25] For a fuller discussion of this problem, see U.S. Library of Congress. Congressional Research Service. *Medicaid Source Book: Background Data and Analysis*. Report prepared for the House Committee on Energy and Commerce. Washington, Nov. 1988. (Committee print 100-AA) p. 467-83. (Hereafter cited as Congressional Research Service, *Medicaid Source Book*.)

[26] Graduate Medical Education National Advisory Committee. *Report to the Secretary, U.S. Department of Health and Human Services*. Washington, 1980.

Even less clear than the extent of the future surplus is its possible effect on medical costs. Observations that per capita use of physician services increases in geographic areas with a high ratio of physicians to population have led to the hypothesis of "physician-induced demand." Just as excess hospital bed capacity may generate more hospital stays, this theory holds that a surplus of physicians all attempting to maintain their incomes would lead --in the absence of any controls--to excess delivery of services. Repeated efforts to demonstrate this have been inconclusive.[28] It is not clear that physicians actually modify their medical practice in order to maintain a "target income." Still, if the projected surplus does in fact appear, there might be greater pressures on physicians to increase the number of services they furnish to each patient. Some people believe that it may eventually be necessary to consider reducing the supply of physicians (or curtailing their working hours).

This has actually been attempted in one Canadian province, British Columbia. A physician who wants to participate in the health program that covers all citizens of the province must have a billing account, and since 1985 the number of accounts has been limited (limits vary by specialty and geographic area). A physician who fails to obtain a billing number cannot earn a living as a physician. Critics of the system contend, however, that British Columbia is merely exporting its physician surplus to other provinces or to the United States.[29] Given the political problems health planners in the United States have experienced in trying to close hospitals, it seems unlikely that British Columbia's efforts could be reproduced here, with government regulators telling new medical school graduates to find some other profession. However, there are proposals to achieve the same goal through private means. Some of the more ambitious "managed care" agendas discussed in the final section of this report contemplate enrollment of the entire population in health maintenance organizations (HMOs) or other structured delivery systems that would match their resources to the needs of the enrolled population; this approach would potentially reduce employment opportunities for physicians.[30]

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[27] For contrasting views on these issues, see Schwartz, William B., Frank A. Sloan, and Daniel N. Mendelson. Why There Will Be Little or No Physician Surplus between Now and the Year 2000. *New England Journal of Medicine*, v. 318, no. 14, Apr. 7, 1988. p. 892-897; Schloss, Ernest P. Beyond GMENAC--Another Physician Shortage from 2010 to 2030? *New England Journal of Medicine*, v. 318, no. 14, Apr. 7, 1988. p. 920-922.

[28] See Rossiter, Louis F., and Gail R. Wilensky. A Reexamination of the Use of Physician Services: The Role of Physician-Initiated Demand. *Inquiry*, v. 20, no. 2, summer 1983. p. 162-72; Langwell, Kathryn M., and Lyle M. Nelson. Physician Payment Systems: A Review of History, Alternatives and Evidence. *Medical Care Review*, v. 43, no. 1, spring 1986. p. 5-58.

[29] Barer, Morris L. Regulating Physician Supply: The Evolution of British Columbia's Bill 41. *Journal of Health Politics, Policy, and Law*. v. 13, no. 1, spring 1988. p. 1-25.

## REIMBURSEMENT REFORM

Proposals for reimbursement reform begin with the premise that traditional payment systems, under which providers receive their full costs or charges for whatever services they choose to furnish, encourage inefficiency and the delivery of unnecessary care.

The simplest type of reform is for payers to set fixed prices for defined units of service, such as a day of inpatient care or a physician office visit. However, this approach may not reduce costs if providers are able to modify the volume or nature of the services they provide to make up for the lost revenue on individual services. For this reason, the focus of reimbursement reform proposals is on developing pricing mechanisms that give providers incentives to control both volume and unit cost.

This is generally accomplished by redefining the commodity the insurer is purchasing. Instead of paying for individual units of service, the insurer makes one payment for an episode of care (as in Medicare's prospective payment system, PPS), for overall treatment of a patient during a given time period (capitation), or for treatment of an entire population (as in Canada's global budgeting system for hospitals). These approaches may be seen as aligned on an ascending scale depending on the degree of aggregation of the unit being purchased, with per-case payment at the low end and payment for an entire patient population at the other. In all cases, however, the aim is to define in advance the total amount of resources the provider may consume in furnishing treatment to a patient or group of patients.

Per-case payment and capitation give the provider an incentive to perform more efficiently in treating individual patients, either reducing the cost of producing each unit of service or reducing the number of units furnished to each patient. These approaches may therefore be seen as alternatives to external utilization controls. Global budgeting defines the total resources available for treating all patients, and may be seen as an alternative to health planning.[31] Reimbursement controls have the same goals as direct regulation of medical practice and supply, but shift the responsibility for decision-making from the third-party payer or the government to the actual providers of care. In order to live within the established rates or budgets, the providers must be self-regulating; they must make the same sorts of treatment and resource allocation decisions that would otherwise have been imposed externally.

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[30] For example, Alain Enthoven has characterized the "buy right" scheme advanced by Walter McClure as requiring that "good-quality, efficient doctors prosper while others are induced to retire." Enthoven, Alain C. Managed Competition in Health Care and the Unfinished Agenda. *Health Care Financing Review*, 1986 Annual Supplement. p. 105-119.

As the Medicare program has demonstrated, it is possible for a single payer with sufficient market power to adopt such reimbursement changes on its own.[32] The effects of this unilateral approach in a pluralistic system are uncertain. While some providers may be driven to improve their efficiency, others may instead respond to shortfalls in reimbursement from one payer by raising charges to other groups, those without the market power to dictate prices. The possibility of "cost-shifting" may mean that savings for one purchaser are not translated into real reductions in total system expenditures.

In a sufficiently competitive market, the providers' ability to engage in this "cost-shifting" may be limited. A hospital may face, not only payment limits under Medicare and Medicaid, but pressure from private insurers or employer groups to grant price discounts in order to be assured of an adequate market share. Characteristics other than efficiency may determine a provider's success in the face of these competing demands. For example, a suburban non-teaching hospital with few uninsured patients may be at a relative advantage as compared to a center city teaching facility with a heavy uncompensated care load. Individual purchasers who reduce their costs by favoring the suburban hospital may leave the society to find some other means of subsidizing essential facilities that are handicapped in price competition.

A system in which multiple payers negotiate individually with providers may, then, lead either to cost-shifting or to a situation in which price concerns override other societal goals, such as medical education and charity care. For this reason, some people argue that real efficiency can be achieved only if all payers are paying under the same rules.

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[31] In practice, the Canadian system uses both global budgeting and health planning. However, some of the rate regulation systems in the United States have explicitly superseded the health planning system. A facility that has obtained a certificate of need for expansion may proceed only if the rate commission approves the necessary increase in capital costs. For a discussion of the interplay of planning and rate regulation, see Brown, Common Sense Meets Implementation.

[32] As the Medicaid experience has shown, adoption of payment restraints by a payer with too small a market share may reduce acess for the payer's enrollees. For example, low reimbursement rates are the major reason physicians decline to participate in the Medicaid program. See Congressional Research Service, *Medicaid Source Bo*[illegible] p. 448-454.

Uniform ratesetting is common in other industrialized nations, both those with single-payer health insurance systems (as in Canada) and those where many different entities provide insurance (as in West Germany). The experience in the United States is limited to experiments in a few States beginning in the 1970s. Federal waivers of Medicare and Medicaid rules made it possible for those two payers to participate in the programs on a demonstration basis, while State laws compelled participation by private insurers and individual payers, resulting in an "all-payer" system. Medicaid law now permits any State to include Medicaid in such a system, and Medicare may be included if the State can show that its system controls costs as effectively as PPS. However, full "all-payer" systems continue only in Maryland and in part of New York State. Several other States operate "partial-payer" systems that include all payers except Medicare.[33] These systems have generally used the price aggregation approaches described above. That is, they either establish a rate for total treatment of a case (as under PPS) or they establish a total budget for a hospital during a year, setting prices for the hospital in such a way as to achieve a target revenue amount.

It has been shown that, in 6 States with ratesetting systems, annual increases in cost per admission were consistently 3 to 4 percentage points below the national average from 1976 to 1984. During the same period, however, other States saw a drop in admissions per capita, while admissions in the ratesetting States were stable. As a result, the difference in growth in per capita rates of spending was not so striking: per capita costs rose at an annual rate of 11.5 percent a year in the ratesetting States and 13 percent a year in other States.[34] In addition, the ratesetting States had much higher costs at the outset than most other States. Some observers have questioned whether ratesetting could have achieved comparable savings in areas where costs were lower to begin with.[35]

Evidence from other countries with universal ratesetting systems suggests that greater savings may be possible. In Canada, where the provinces establish global budgets for each hospital, hospital expenditures per capita were one-third lower than in the United States in 1985. (Similar systems in other industrial nations have been less successful.)[36] As admission rates are not markedly lower, there is considerable uncertainty about the sources of the difference. Some of the saving may be in administrative costs, simply because the hospitals do not need to meet the paperwork requirements of multiple payers. The rest of the difference is often attributed to differences in the intensity of the services furnished to each patient. Whether these differences reflect "underservice" in Canada or "overservice" in the United States is the subject of continuing debate.[37]

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[33] Maine's system takes hospitals' Medicare revenues into account when determining what the hospitals may charge other payers, thus achieving overall budgetary control without direct Medicare participation. This approach has recently survived a legal challenge by hospitals.

[34] Schramm, Carl J., Steven C. Renn, and Brian Biles. New Perspectives on State Rate-Setting. *Health Affairs*, v. 5, no. 3, fall 1986. p. 22-33.

[35] Eby, Charles L., and Donald R. Cohodes. What Do We Know About Rate-Setting? *Journal of Health Politics, Policy, and Law*, v. 10, no. 2, summer 1985. p. 299-327.

In a sense, the statistical evidence may be beside the point. An all-payer system could in theory fix its prices at any level, with the potential consequence of reduced access or quality if the prices are set too low. The available data may thus be taken as indicating, not the savings that could hypothetically be achieved, but the savings that were politically feasible in specific States during a specific period. Continuing pressure by consumers and providers for the adoption of new medical technologies may limit the ability of ratesetting systems to restrain expenditure growth over the long term. Even in Canada, overall medical expenditures outpaced inflation by 2.9 percent a year in the period 1980-87, almost the same as the 3.0 percent annual rate observed in the United States in the same years.[38] The ultimate efficacy of reimbursement controls may depend, in the same way that the success of health planning depends, on the political will to constrain health care consumption.

That political will might in turn depend on perceptions of the impact of reimbursement controls on the quality of care. The effect of Medicare's prospective payment system, for example, has been argued continuously since its implementation in 1983. One of the immediate responses of hospitals to the incentives of the new system was to shorten the average length of stay in the hospital for each Medicare patient (although average length of stay had already been dropping for several years). Opponents of the new system have contended that patients were being discharged "quicker and sicker," transferred to their own homes or to nursing homes at a stage in their recovery when they still required hospital-level care. Because of a lack of satisfactory measures of medical care outcomes for large populations, evidence on this issue remains largely anecdotal. Still, the possibility that there has been a deterioration in quality of care for at least some Medicare patients since the implementation of PPS cannot be ruled out. The hospitals themselves argue that current payment levels are insufficient to maintain adequate quality. At the same time, the Administration and the Prospective Payment Assessment Commission (the independent commission that reviews PPS) have argued that hospitals are still not operating at peak efficiency and that further payment restraint is needed to provide continued incentives for cost reduction.[38]

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[36] Organisation for Economic Co-Operation and Development. *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*. Paris, 1987. (OECD Social Policy Studies No. 4.) p. 63.

[37] For a variety of views on this subject, see the series of articles on Canada's hospital system in *Health Affairs*, v. 7, no. 5, winter 1988.

[38] Schieber and Poullier, International Health Care Expenditure Trends:
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This debate illustrates one potential dilemma in the strategy of achieving savings by relying on the political process to limit the financial resources available to providers. On the one hand, legislators driven by budgetary concerns may continue to ratchet down spending limits until they have clear evidence that quality has been seriously affected. On the other hand, provider or constituent pressure may lead them to relax those limits before the providers have done everything possible to improve their efficiency. Because no one knows the ideal amount to spend on medical care, some people say that this process can never achieve equilibrium and that cost control efforts should instead depend on the process through which other sectors of the economy achieve "correct" spending levels: the free market. Proposals for encouraging competition in health care represent the last of the strategies to be reviewed in this report.

## COMPETITION

The idea of reducing health care costs by promoting competition in the health care marketplace was first advanced in the 1970s. Some analysts, arguing that such initiatives as rate regulation, health planning, and utilization review had been compromised by political interference, contended that the free market was better equipped to control costs than Government was. By the early 1980s, this view had wide currency and had become the official policy of the Reagan Administration. Since then, there has been a continuing debate between advocates of competition and those who favored further regulatory interventions by Government. The debate has been complicated by a lack of agreement over what "competition" consists of. What is the health care market? Who are the purchasers, and what are they buying?

In a simple market, hospitals and physicians would compete directly for the individual consumer's dollar. The consumer would pick the best values just as he or she does when buying any other commodity. As was suggested in the discussion of cost-sharing, it is not clear that consumers are capable of making such evaluations; moreover, many purchasing decisions are made by physicians on their patients' behalf, rather than directly by consumers. Finally, because few people can afford the costs of care for a major illness, most of the consumer's dollar is spent on health insurance, not on medical care itself. As was suggested earlier, this is true even when the insurance plan imposes cost-sharing requirements on enrollees, because most health care costs are incurred by a relatively small number of high-cost cases. For this reason, most proponents of competition are really talking about price competition among insurers, and only indirectly among providers.

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[38] U.S. Prospective Payment Assessment Commission. *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*. Washington, U.S. Govt. Print. Off., Mar. 1989; For a recent review of hospital cost responses to PPS, see Sheingold, Steven H. The First Three Years of PPS: Impact on Medicare Costs. *Health Affairs*, v. 8, no. 3, fall 1989. p. 191-204.

If the insurer is--as traditional health insurance plans were--a passive payer for services obtained by policyholders, there is little room for serious price competition. The only element of cost that the insurer can control is its own administrative cost. Competition, if any, may turn on such non-price factors as reputation or the insurer's ability to screen out high-risk applicants.[40]

Competition among insurers can result in real cost savings only if the insurers have some influence on the costs of health care itself. In this model, insurers compete to offer lower prices by acting as prudent purchasers, proxies for the rational consumer. The insurers are selling a new product, no longer simply insurance, but "insured health care." To some extent, this new insurance market has already arrived. As was suggested earlier, most insurance plans, both public and private, have adopted some utilization control measures. Very few insurers are still passive bill-payers.

Once all insurers have adopted these basic cost control measures, further competition would presumably require more aggressive interventions by insurers in the health care system. Proponents of competition contemplate a marketplace in which insurers develop structured delivery systems, with the highest profits going to those whose networks are most efficient. The prototype for these systems is the HMO. More recently, some insurers have been experimenting with hybrid programs, such as "point-of-service plans," that are less structured and provide somewhat greater flexibility to enrollees.

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[40] Alain Enthoven has summarized the alternatives to price competition: "[S]election of preferred risks, market segmentation, product differentiation that raises the costs of comparing products, discontinuity in coverage, refusal to insure certain individuals or exclusion of coverage for treatment of preexisting medical conditions, biased information regarding coverage and quality, and erection of entry barriers [that is, to new competitors]." Enthoven, Alain C. Managed Competition of Alternative Delivery Systems. *Journal of Health Politics, Policy and Law*, v. 13, no. 2, p. 305-321.

## Health Maintenance Organizations

A health maintenance organization (HMO) is a form of health insurer; like any other insurer, it accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium. Unlike other insurers, HMOs directly provide or arrange for health care services, through affiliated physicians, hospitals, and other providers. The enrollees covered by the HMO agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers. The HMO has no liability to pay for unauthorized non-urgent care obtained outside the organization. Ordinarily, the enrollee's point of entry into the system is through a single primary care provider, who functions as a "gatekeeper," determining when a patient may see a specialist or be admitted to the hospital. The HMO exerts further administrative controls on use of services through authorization mechanisms and/or treatment protocols. HMOs also use a variety of other cost-saving techniques, such as negotiated discounts with providers and payment mechanisms that place individual providers at risk for the costs of the services they furnish or order.

The particular cost-saving techniques adopted by HMOs and other "managed care" plans are not fundamentally different from the regulatory approaches described in the preceding sections. An HMO imposes external utilization review on its participating providers and may develop practice guidelines or protocols. Staff or group practice model HMOs (those that employ physicians on a full-time basis) impose supply constraints, limiting available resources to those needed by their membership. Individual practice associations (IPAs, whose physicians practice in their own offices and see a mix of HMO and non-HMO patients) use payment methods that create financial incentives to control utilization, such as capitation or expenditure targets.

One additional cost-saving approach that was once unique to HMOs is "gatekeeping." Under a gatekeeping approach, a patient receives all non-emergency care from, or with the authorization of, a single primary care provider. The provider thus functions as a "gatekeeper," preventing the enrollee from independently accessing specialists or other services and presumably managing the overall care of the patient. The extent to which gatekeeping produces savings over and above those provided by the other cost-saving techniques adopted by HMOs is uncertain. The results of one experiment, the SAFECO health plan operated by United HealthCare in the early 1980s, suggest that gatekeeping alone has little effect on overall cost. While primary care providers reduced the number of referrals to specialists, they were unable to control the behavior of the specialists once a referral had occurred. There was no meaningful reduction in hospital admissions, 70 percent of which were controlled by the specialists.[41] Greater success has been reported by some State Medicaid programs, which have established "primary care case management" programs for segments of their covered populations. Gatekeeping reduced such inappropriate behaviors as the use of emergency rooms for primary care. However, the utilization patterns addressed by these programs may be characteristic of Medicaid beneficiaries in the inner city and not of other groups; it is not clear that equivalent savings could be achieved with a general population. There is some evidence that most patients' care is already "managed" by their primary care physicians, at least to the extent that it is managed under formal gatekeeping arrangements.[42]

Aside from the uncertain effects of gatekeeping, managed care depends on the same kinds of interventions in medical care practice, supply, and financing that might otherwise be attempted on a regulatory basis. The difference is that, instead of relying on the political process to make decisions about the allocation of health care resources, managed care privatizes these decisions. The choice among alternative cost control methods--and the stringency with which these methods will be applied--will be made by the free market. The fundamental contention of proponents of the competitive approach is that the market can impose discipline on the health care system that cannot be imposed through external regulation.

This contention rests on two key assumptions: first, that buyers will, all other things being equal, select the most cost-effective plan; second, that managed care offers greater cost-saving potential than the various regulatory controls described earlier.

One critical factor has made it difficult to generalize about the efficacy of HMOs as a cost-saving approach: the problem of "biased selection" in systems that allow a choice between a conventional health insurance plan and an HMO. Numerous studies of such "dual choice" employer group plans have shown that the members of the group choosing the HMO option used fewer health services before their enrollment than persons who chose an conventional plan. Similar patterns have been observed in Medicare HMO enrollment.[43] This does not necessarily mean that HMO enrollees were healthier. Studies using self-reported condition and similar limited measures of health status have found no difference between HMO and indemnity enrollees. It may be, then, that HMO enrollees are simply less prone to seek health services, regardless of their condition.[44]

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[41] Moore, Stephen, Diane Martin, and William Richardson. Does the Primary-Care Gatekeeper Control the Costs of Health Care? Lessons from the SAFECO Experience. *New England Journal of Medicine*, v. 309, no. 22, Dec. 1, 1983. p. 1400-1404; For the extent to which specialty referrals may determine overall costs, see Glenn, John K., Frank H. Lawler, and Mark S. Hoerl. Physician Referrals in a Competitive Environment: An Estimate of the Economic Impact of a Referral. *Journal of the American Medical Association*, v. 258, no. 14, Oct. 9, 1987. p. 1920-23.

[42] Dietrich, A.J., et al. Do Primary Physicians Actually Manage Their Patients' Fee-for-Service Care? *Journal of the American Medical Association*, v. 259, no. 21, June 3, 1988. p. 3145-49.

In groups that have no HMO option but do offer a choice between high- and low-option plans the common selection pattern is for the higher users of services to choose the more comprehensive plan.[45] In most group health programs offering a choice between HMOs and conventional plans, the HMO options offer more comprehensive coverage, with less enrollee cost-sharing, than even a high-option conventional plan. That higher users of services still prefer the conventional plan suggests that non-financial aspects of HMOs affect the decision, such as limited choice of providers, bureaucratic constraints on treatment, or waiting time for non-urgent care. There is stronger evidence of biased selection for staff and group model HMOs, the most restrictive, than for IPAs, which are less likely to disrupt enrollees' traditional ways of obtaining medical care.

Possible solutions to the problem of selection bias will be discussed further below. One immediate consequence, however, is that the differences between the populations in HMOs and conventional plans have made it difficult to determine whether HMOs are actually more efficient than other insurers. Only one major study has corrected adequately for this problem. In a second component of the RAND Health Insurance Experiment (HIE) cited earlier, enrollees were randomly assigned to the Group Health Cooperative of Puget Sound and an equally comprehensive conventional plan; neither plan required cost-sharing. This arrangement allowed comparisons of efficiency with identical benefits and populations with comparable health needs. The results strongly confirmed the cost-saving potential of the HMO. The HMO enrollees had 40 percent fewer hospital admissions; their use of ambulatory services was about the same as that of the conventional enrollees. Overall, costs for the HMO group were estimated to be 28 percent lower than for the control group.[46] There were no perceived effects on quality; measures of health outcomes were generally the same for both groups.[47]

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[43] For a review of the evidence, see U.S. General Accounting Office. *Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings*. Report to the Chairman, Subcommittee on Health, House Committee on Ways and Means. Washington, Nov. 1989. [GAO/HRD-90-38]

[44] Hellinger, Fred J. Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence. *Health Care Financing Review*, v. 9, no. 2, winter 1987. p. 55-63.

[45] Broyles, Robert W., and Michael D. Rosko. The Demand for Health Insurance and Health Care: A Review of the Empirical Literature. *Medical Care Review*, v. 45, no. 2, fall 1988. p. 291-338.

While the HIE findings are persuasive, two factors may limit the general applicability of the results. First, the study was conducted in the late 1970s; the comparison plan was the passive bill-payer prevalent in the insurance industry in that period, with no utilization control mechanisms. The more recent adoption by conventional plans of some of the cost-control measures once associated only with HMOs may mean that the difference in efficiency between the two types of plan has narrowed.

Second, the HMO used in the Health Insurance Experiment was a highly structured group-practice plan with many years of operating experience. Much of the growth in the industry in recent years has involved a different type of HMO, the individual practice association (IPA), which contracts with independent physicians who see a mix of HMO enrollees and other kinds of patients. There is evidence that these more loosely structured HMOs have not achieved savings comparable to those observed in the HIE.[48] Physicians may not modify their styles of practice in treating HMO enrollees if those enrollees constitute only a small share of their practice. In addition, some people believe that HMOs cannot impose cost-consciousness on practitioners who have not "signed on" to the concept of more efficient and less resource-intensive practice. Because so little is still known about the relative efficacy of different medical practices, external utilization controls may not be able to override individual physicians' judgment in many cases. The greater success of the "closed panel" plan, whose physicians treat HMO enrollees exclusively, has been attributed by some observers to the possibility that these plans attract physicians who are temperamentally more prone to conservative medical practice.

Because closed panel plans maintain their own medical facilities, they require greater start-up funding than IPAs. Federal funds were available to develop such plans in the 1970s, but new plans must now rely on private investment. Investors have favored IPAs, not only because they require less capital, but also because the wider selection of physicians makes them more attractive to consumers. This attraction may, however, be purchased at the price of reduced efficiency.

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[46] Manning, Willard G., et al. A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services. *New England Journal of Medicine*, v. 310, no. 23, June 7, 1984. p. 1505-10.

[47] Ware, John E., Jr., et al. Comparison of Health Outcomes at a Health Maintenance Organisation With Those of Fee-for-Service Care. *Lancet*, May 3, 1986. p. 1017-22. One group, low-income HMO enrollees with existing health problems, had poorer outcomes, possibly because of difficulty dealing with the HMO's internal bureaucracy.

[48] For the most recent findings, see Hillman, Alan, Mark Pauly, and Joseph Kerstein. How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations? *New England Journal of Medicine*, v. 321, no. 2, July 13, 1989. p. 86-92.

Finally, while some types of HMOs or similar organizations may be able to reduce costs relative to conventional plans, it is not clear that they have so far reduced growth in health care costs. Data from 1961 through 1981 suggest that HMOs may instead achieve a one-time saving, after which costs rise at the same rate as those for other insurance programs. One explanation that has been offered is that providers in HMOs are as likely as other providers to use new medical technologies.[49] More recent data suggest that HMO premium increases have continued to resemble those of conventional insurance plans. The average HMO premium increase during 1988 was 17.2 percent, very close to the 19 percent increase for all employer coverage cited at the beginning of this report.[50]

That HMO cost increases have paralleled those of other insurers does not necessarily mean that HMOs have reached the limit of their cost-saving potential. Because competition among health insurers was relatively limited until recent years, many HMOs may not have faced the market pressures that could induce them to achieve greater savings. The next section reviews proposals to strengthen competition.

### Competition and Consumer Choice

The competitive strategy depends on the willingness of consumers to choose the most cost-effective plans. As was suggested earlier, the consumers most likely to incur high costs may be least likely to choose the most efficient option. The problem of biased selection might persist even if conventional insurance plans were to disappear and consumers were able to choose only among managed care options. (Some industry analysts believe this will occur in the near future, chiefly because employers will refuse to offer conventional plans.) It is possible that the most costly patients, given a choice among competing managed care plans, would choose the plan that was least restrictive and potentially least able to achieve cost savings. The most efficient plans might continue to enroll the healthiest patients, for whom only limited savings are possible.

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[49] Newhouse, Joseph P., et al. Are Fee-for-Service Costs Increasing Faster Than HMO Costs? *Medical Care*, v. 23, no. 8, Aug. 1985. p. 960-66.

[50] InterStudy. *The Bottom Line: HMO Premiums and Profitability, 1988-1989*. Excelsior, Minn., 1989. Staff and group model HMOs generally had lower increases, possibly confirming their greater efficiency. However, these HMOs also tend to be older than IPAs; age of the HMO was also a determinant of the rate of increase.

Some people believe that biased selection is largely attributable to the fact that consumers are economically sheltered from the cost of their choice of plan, because most of the premium is paid by the employer. Various schemes have been advanced to make the employee more cost-conscious. For example, the employer's contribution might be tied to the cost of the least expensive offering, with the employee bearing the full cost of the difference between that plan and other more expensive options.

However, selection bias can occur even when the choice of the more expensive plan has real financial consequences for the enrollee. Under the Federal Employees Health Benefits Program (FEHBP), the monthly employee share of premium costs in 1990 ranges from $20.54 in the least expensive high-option HMO to $234.07 in the most costly high-option conventional plan, a difference of $213.53 per month.[61] Under one possible fixed contribution scheme, the Federal share of both plans would be set equal to the full cost of the HMO ($82.16); the employee share would then be zero for the HMO and $265.29 for the conventional plan. If some Federal employees or annuitants are already willing to pay 11 times as much as others in order to obtain the conventional plan, it is not clear that even this change would cause all of them to shift to the HMO. For at least some subset of enrollees, the preference for unrestricted coverage is apparently sufficient to override even strong financial incentives.

One possible solution to the problem of enrollee self-selection is to abandon multiple choices and oblige all members of a covered group to enter a single plan, one selected by the employer or other buyer from among competing plans. Assuming that employers disregarded their own personal plan preferences and chose the least costly option, this approach would theoretically lead to competition among plans on the basis of efficiency. However, both employers and HMOs have been hesitant to enter into arrangements under which enrollees are unwillingly locked into a highly restrictive plan. For this reason, there have evolved arrangements even less restrictive than IPAs, known as open-ended or point-of-service plans.

The predecessor of these plans is the preferred provider organization (PPO). PPOs negotiate discounted rates with certain providers. Enrollees are given a financial incentive, in the form of reduced deductible or coinsurance requirements, to obtain care from providers participating in the PPO network. However, payment will be made under the plan for services furnished by any provider. PPOs thus differ from HMOs, which deny payment altogether for unauthorized non-emergent care provided by providers outside the HMO network. While some PPOs have adopted managed care techniques, such as the use of gatekeepers, most of the savings from a PPO are expected to result from encouraging enrollees to use the participating providers.

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[61] The conventional plan is national, while HMOs are offered only in specific locations. The comparison presented here applies only in one area (Tampa, Florida) and represents the extreme of variation in the FEHBP system.

The newer, open-ended plans are hybrids, combining some features of HMOs and PPOs. Typically, the plan operates a structured health care system comparable to that of an IPA-model HMO. Enrollees are expected to access the system through a primary care gatekeeper and obtain services from other network providers upon referral by the gatekeeper. Like an HMO, the plan also imposes external utilization controls and negotiates price discounts with providers. As in a PPO, enrollees are free to use non-network providers for covered services, but must pay higher cost-sharing amounts if they choose to do so. Enrollees are also subject to higher cost-sharing if they use specialists within the network without the authorization of the gatekeeper.

Open-ended plans have been adopted by some employers as the single plan available to their workers, replacing systems in which the workers had a choice between conventional and HMO options. Their attraction has been that they overcome the possible selection bias in dual choice systems by enrolling all employees in an HMO-like program. At the same time, they can reduce the employee resistance that would probably greet a proposal for universal HMO enrollment, because they offer employees the safety valve of being able to choose non-plan providers.

Officials of some major insurers that have experimented with open-ended plans in multiple markets report that the plans appear to be reducing the rate of health care cost increases, relative to the increases for their conventional offerings in the same markets.[52] Because these plans began operations only very recently, the data required for an objective evaluation are not yet available. Even PPOs, which have existed for a decade, have never been the subject of a controlled study. Some preliminary findings, however, suggest that the safety valve that makes PPOs attractive is potentially a serious weakness, one which may carry over to the newer hybrid plans.

One recent study of a PPO found that enrollees used the PPO's providers for preventive care and minor illnesses, but went outside the network about half the time for specialty care, major surgery, and hospitalization without surgery.[53] One study found a similar pattern among PPO enrollees who were actually employees of one of the providers in the

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[52] Personal communication with officials of Prudential and CIGNA.

[53] Wouters, Annemarie, and James Hester. Patient Choice of Providers in a Preferred Provider Organization. *Medical Care*, v. 26, no. 3, Mar. 1988. p. 240-255. The results may not be fully representative, because the PPO studied was somewhat skewed towards primary care providers.

PPO network.[64] While these findings are not definitive, they suggest a dilemma that may be common to both PPOs and the newer types of managed care plans. If the price for going out of plan is not punitive, enrollees may obtain much of their care outside the network; if the price is set high enough to deter outside utilization, the plan may lose its relative attractiveness.

Both solutions to the biased selection problem, higher premiums for the non-HMO plan or higher cost-sharing for using non-HMO providers, may then face the same potential barrier: the highest-risk enrollees, those for whom the greatest potential savings presumably exist, may be willing to pay much more out-of-pocket to retain free choice of providers and avoid bureaucratic restrictions. While the problem might be overcome by making the cost of unrestricted health care prohibitive, this solution may be foreclosed by the potential strain on labor relations (or, in the case of public programs, political resistance).

One other solution that has been proposed is to go to the roots of consumer resistance to managed care, the concern about quality. Some analysts argue that, because consumers have little information about the relative quality of different medical care providers, they must rely on "signals" of quality sent out by various providers, such as the use of elaborate technology or aggressive medical treatment styles.[65] If the persons with the highest expectation of requiring medical services will accept financial sacrifices to avoid managed care programs, this may be because they cannot evaluate the care offered by such programs and wish to remain free to seek out the providers who more actively signal quality. This preference might be overcome if consumers had reliable data on the actual quality of the care furnished by different providers or provider systems such as HMOs.

This view has led to such proposals as the "buy right" plan advanced by Walter McClure of the Center for Policy Studies in Minnesota. Under this plan, a community would collect and make available to consumers uniform data on patient outcomes from all providers. Consumers would then be in a position to determine whether the higher cost providers were actually furnishing superior care and could thus make rational purchasing decisions. The proposal assumes that the community can agree on objective measures of quality. Past efforts to develop uniform bases of comparison have been controversial. For example, the annual release by the Health Care Financing Administration of mortality data for Medicare beneficiaries in hospitals has been criticized on the grounds that numerous factors other than relative proficiency can affect the death rates of hospital patients. Highly specialized facilities may be treating the most seriously ill patients; facilities serving a low-income population may find that more of their patients have delayed medical treatment beyond the point at which they could be helped. Full implementation of the "buy right" strategy might have to wait until research can provide acceptable standardized outcome measures.

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[64] ehr, Paula, et al. Use of a Preferred Provider by Employees of the Preferred Provider. *Health Services Research*, v. 23, no. 4, Oct. 1988. p. 537-554.

[65] For an elaboration of this theory, see Robinson, James C. Hospital Quality Competition and the Economics of Imperfect Information. *Milbank Quarterly*, v. 66, no. 3, 1988. p. 465-81.

Assuming that those measures can be developed, how would competition then work? Consumers would be fully informed about the relative price and quality of competing health plans, and would thus be equipped to make medical care purchasing decisions in the same way that they decide about other purchases. Proponents of competition argue that the power of the market would then compel all providers to make steady improvements in both quality and efficiency. However, if the health care market could be induced to evolve in the same way as other markets, it is not necessarily the case that the end product would be a single class of providers uniformly striving to achieve the same goals. The health care market could instead be segmented in the way that the markets for other goods and services are; there might be economy and luxury health plans just as there are economy and luxury automobiles. Improving the information available to health care consumers might mean only that buyers would be better able to distinguish between the two, not that the distinction would cease to exist. Whether Americans are prepared to accept the same price/quality tradeoffs in buying medical care that they do in buying other products is an open question.

# Health Care Reform: Managed Competition

## SUMMARY

Congress is considering a range of proposals to control growth in health spending. One receiving wide attention is *managed competition*, under which consumers would choose from among competing health plans and would be given financial incentives to select the most cost-effective. Plans using this approach have been introduced in Congress by the House Conservative Democratic Forum and by Senator Bingaman, and President-elect Clinton has indicated that managed competition will play a part in his health reform package.

Proponents of competition contend that the favorable tax treatment of health benefits and other factors have encouraged workers to choose inefficient health plans. They would change financial incentives to make consumers more prudent purchasers. To insure that purchasers could assess the price and quality of different plans, an intermediary, the *health insurance purchasing cooperative* (HIPC), would be established between the consumer and the competing health plans. By selecting qualified plans, standardizing benefits, and providing quality information, the HIPC would "manage" the market. In most proposals, HIPC participation would be required for all purchasers in an area or for defined subgroups (such as small employers and/or individuals buying coverage on their own). Several different insurers would arrange with the HIPC to offer health benefit plans. Each individual or family participating in the HIPC would select from among the different plans offered. In order to facilitate consumer choice, the HIPC would collect and disseminate information on the quality and costs of the participating plans.

Through tax system changes, families would be given an incentive to choose the least costly plan offered through the HIPC and meeting specified benefit and quality standards. The expectation is that many people will opt for "managed care" plans, such as health maintenance organizations, which arrange for covered services through affiliated provider networks and seek to provide care with maximum efficiency.

Perhaps the key issue in evaluating managed competition is its ability to achieve savings. There is evidence that tightly structured HMOs can cut costs over the short term, although they do not appear to reduce long-term spending growth. Competition proponents say that market pressure will produce greater savings. However, it is not certain that most consumers would select highly restrictive HMO plans (nor would such plans be available immediately in many areas). Some proposals would have a regulatory back-up available (such as limits on premium increases) if competition failed to achieve savings.

Some people raise concerns that competitive pressure could lead plans to deny necessary services, or that lower-income people could be forced into a basic plan, while others could buy coverage offering higher quality care. Finally, limits on tax benefits are central to the concept of giving consumers incentives to be prudent purchasers. For workers now receiving more costly health benefits, however, these limits would mean a tax increase or a reduction in benefits. Debate over this component is likely to be a major issue in consideration of the competitive approach.

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## Most Recent Developments

**Preliminary versions of President-elect Clinton's health care reform plan would include a managed competition approach, along with some form of spending limits.**

## BACKGROUND AND ANALYSIS

Congress is considering a wide range of proposals to control the growth in health care spending. Many focus on particular factors thought to contribute to rising costs; for example, there are numerous plans for administrative simplification or for reforming the malpractice liability system. Other proposals, however, call for a more fundamental restructuring of the way medical care is paid for. One option now receiving considerable attention is **managed competition**, under which consumers would choose from among a variety of competing health plans and would be given financial incentives to select the most cost-effective.

President-elect Clinton has indicated that managed competition will play a part in his health care reform proposal; the Bush Administration's proposal also included elements of this approach. A number of bills incorporating the concept were introduced in the 102nd Congress, including H.R. 5936 (Cooper)/S. 3299 (Boren), the House Conservative Democratic Forum proposal, and S. 3300 (Bingaman). Widely discussed managed competition proposals have also been advanced by a private ad-hoc organization known as the Jackson Hole Group and by California Insurance Commissioner John Garamendi.

The managed competition option is commonly discussed in the context of proposals to provide or assure access to universal health coverage. Managed competition schemes have been incorporated in bills providing for universal public coverage, for mandated employer coverage, or for individual purchase of private insurance with public subsidies. Thus, there is no necessary connection between the selection of this cost containment approach and the preferred approach to guaranteeing access. It is important, then, to distinguish between the access/financing component of a proposal -- how people will get basic coverage and how the coverage will be paid for -- and the cost containment component. This brief will focus chiefly on managed competition as it might be implemented in the current health system, with its mix of public coverage and private coverage paid for by employers and individuals. The summaries of specific proposals will describe how managed competition has been combined with different access/financing approaches.

### Evolution of the Concept

Managed competition proposals begin with the premise that the market for health services is not truly competitive and that strengthening market competition would lead to greater efficiency and quality. Because most services are covered by insurance, consumers have no reason to consider the costs or efficacy of the care they obtain. In addition, consumers are largely sheltered from the costs of insurance itself. Most people

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are covered through employment, and the employer's contribution to health benefit plans is excluded from workers' income for tax purposes.

Some economists have long argued that the key to controlling health care costs is to limit or eliminate the favorable tax treatment of health benefits, thus encouraging workers to choose less costly insurance. In the classic view, represented by such proposals as the Heritage Foundation plan, consumers would shift to plans with higher deductible and coinsurance payments. As they began to pay more of their medical bills directly, they would become more prudent purchasers of services, avoiding overpriced or ineffective care. (For a description of the Heritage Foundation plan and other tax-based proposals, see *Health Care Reform: Tax System Approaches*, CRS Issue Brief 93002.) One objection to this approach has always been that consumers were not actually in a position to act as prudent purchasers. They cannot evaluate whether a given lab test or operation is appropriate and so defer to the judgment of their physician. For many patients, greater cost-sharing might merely shift costs from the insurer to the consumer without reducing overall spending. In addition, most medical care is consumed by a small number of individuals with catastrophic costs. Assuming that any insurance plan would still have some limit on individuals' out-of-pocket spending, increased front-end deductible and coinsurance costs might have no effect on this spending.

Early competition proposals, in the 1970s, sought to address these problems by shifting the focus from greater consumer cost-sharing to greater incentives for efficiency on the part of insurance plans. Workers would still be encouraged to buy less costly coverage by reducing tax-favored employer payments. But the least costly coverage would be the plan that managed care most effectively, not the plan with the highest cost-sharing. The prototype for this approach was the health maintenance organization (HMO).

An HMO is a form of health insurer. Like other insurers, it accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium paid by or on behalf of each enrolled member. Unlike other insurers, HMOs directly provide or arrange for health care services, through affiliated physicians, hospitals, and other providers, instead of simply paying bills. The enrollees covered by the HMO agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers. An HMO attempts to reduce costs by managing enrollees' use of services. It may reduce unnecessary hospitalizations, diagnostic tests, or specialty referrals, either through programs to review the use of services or by giving participating physicians a financial stake in the cost of the services they order. It may also select low-cost providers of services or negotiate discounted rates from providers.

Federal start-up assistance for HMOs in the 1970s, along with the belief of many employers that HMOs could reduce their health benefit costs, led to rapid growth in the industry. In 1970, there were 26 HMOs or comparable prepaid plans in the United States, with a total enrollment of 2.9 million. By 1990, according to the Group Health Association of America (GHAA), there were 569 HMOs reporting a total enrollment of 36.5 million.

Beginning in the early 1980s, other types of "managed care" plans have developed. These include preferred provider organizations (PPOs) and "open-ended" or "point-of-service" HMOs. As in traditional HMOs, these arrangements provide covered services through provider networks. Enrollees are given financial incentives to use services within the plan's provider network, but still receive some coverage even if they decide to obtain care from outside providers. These arrangements may be more attractive to consumers who wish to retain some freedom of choice of providers, and they have grown even faster than HMOs in recent years. According to the Health Insurance Association of America (HIAA), PPOs and point-of-service plans accounted for 18% of enrollees in employer group health plans in 1990, compared to 20% in HMOs. Most indemnity or "fee-for-service" plans, which allow unlimited choice of providers, have also adopted at least some techniques associated with managed care, such as pre-admission approval of elective hospital stays. Only 5% of employees in 1990 were still in plans with no utilization management. (Although some insurers speak of conventional plans with some utilization management as "managed care," the phrase is more commonly limited to plans with some form of affiliated provider network.)

The dramatic increase in the use of managed care has not been accompanied by any apparent slowdown in the growth of national health spending. Managed competition advocates contend that this problem reflects the continuing ineffectiveness of the market. Because the tax law still favors more costly coverage, consumers have a limited incentive to choose a more efficient plan. The confusing variety of available benefit packages makes price comparison difficult, and consumers lack reliable information on the quality of different plans. In addition, many insurers may compete, not on the basis of efficiency, but on the basis of their ability to screen out high-risk applicants and enroll low-cost patients.

Another key problem has been "biased selection." Many persons are resistant to the restrictions inherent in HMOs; they want to choose their own doctor. As a result, younger and healthier people may tend to choose HMOs, while the older and sicker ones stay with conventional indemnity coverage and continue to incur high costs. This means, not only that costly patients fail to receive managed care, but also that HMOs may be under less pressure to operate efficiently than they would be if they served a fully representative population.

The current managed competition proposals seek to address many of the structural problems of the market by introducing an intermediary, often termed a **health insurance purchasing corporation** (HIPC), between the consumer and the competing health plans. By selecting qualified plans, standardizing benefits, and providing quality information, the HIPC would manage the market, ensuring consumers a real choice among plans competing on the basis of quality and efficiency. (Note that the phrase "managed competition" refers to this feature of the proposals, managing or regulating the market, rather than to the use of "managed care" plans.)

Despite this refinement in competition proposals, the basic mechanism for promoting competition is unchanged: consumers would be required (through tax system changes or other means) to bear the entire cost of choosing any but the least costly health plan meeting minimum standards. From the perspective of many workers, this means taking a benefit they now perceive as free -- access to employer-paid indemnity coverage -- and charging them for it. Debate over this key component is likely to be a major issue in congressional consideration of the competitive approach.

## Basic Model

Purchasers of health insurance coverage, whether employers or individuals, would join together in a HIPC. The HIPC could be organized by the purchasers themselves in a voluntary association. However, most proposals would require HIPC participation for all purchasers in the HIPC's geographic area or for defined subgroups (such as small employers and/or individuals buying coverage on their own). Several different entities (insurers or insurer/provider networks) would arrange with the HIPC to offer health benefit plans to HIPC participants. The HIPC might enter into agreements with any insurer that met minimum quality and financial standards, or it might be given the power to limit the number of participating insurers.

The HIPC (or a State or national board) would define a basic plan, the minimum scope of benefits that must be provided by all participating insurers. Insurers might be allowed to offer plans with benefits beyond the minimum, such as prescription drug coverage or a reduced deductible. Or they might all be required to offer the same plan, with plans differing only in coverage of non-essential "amenities," such as payment for a private room in a hospital. Plans would then differ chiefly in their arrangements with providers. Some would be HMOs, others would be PPOs or other less restrictive managed care plans, and there might still be an indemnity option allowing unrestricted choice of providers.

Each individual or family participating in the HIPC would select from among the different plans offered. This individual selection would occur even if the consumer was part of an employer group and the employer paid for coverage; the individual, not the employer, would choose the plan. If the individual changed jobs, moving from one employer to another in the same HIPC, the individual could remain enrolled in the same plan. An individual could change plans at given intervals, such as once a year.

Each plan would agree to accept every individual who selected it; no one could be excluded on medical or other grounds, nor could rates vary on the basis of health status or similar characteristics. Individuals would enroll in their selected plan through the HIPC; in most proposals, a plan could not market directly to individuals. (This feature is intended to prevent plans from screening out high-risk applicants and to reduce administrative costs.) In order to facilitate consumer choice among plans, the HIPC would collect and disseminate comparative information on the quality and costs of the participating plans. Ability to furnish this data would be a key factor in a plan's eligibility for HIPC participation.

Most proposals also attempt to address the problem of biased selection through some form of risk adjustment. The HIPC would reduce premium payments for plans found to have lower-risk populations and increase payments for plans with higher-risk enrollees. The mechanisms for doing so are discussed below.

Through bidding or some other process, the HIPC would establish the lowest premium rate offered by any participating insurer for a plan providing at least the minimum required benefits. This would then become the base price for HIPC coverage. Employers would be discouraged (through changes in the tax code) or forbidden to contribute more than this amount towards employees' coverage. If individuals were eligible for some form of public subsidy, whether direct or in the form of tax credits or deductions, the maximum subsidy would be set equal to the base price. Any consumer could join the least costly plan for the base price. If the consumer wished to join a more expensive plan, he or she would pay the entire difference between that plan's premium and the base price, without any employer or public assistance. All consumers would thus be given a financial incentive to select a less costly plan. Those with very low incomes might have no choice but to enroll in the minimum plan, although some proposals include mechanisms that would distribute low-income enrollees among several plans.

## Implementation Issues and Options

Actual implementation of the managed competition concept raises numerous issues. The following is a summary of a few of them and is not meant to be exhaustive.

**HIPC**. The Bush Administration proposal and some others have called for voluntary HIPC formation, for example by organizations of small businesses. There might be multiple HIPCs in a single area, and any purchaser could decide whether to buy coverage through a HIPC or deal with an insurer directly. At least three concerns have been raised about this approach. First, there might be many small HIPCs, none of which had sufficient bargaining power to get the best prices from competing insurers. Second, no one would enter a HIPC who could obtain a better price outside the HIPC; HIPCs might attract only high-risk groups or individuals. Third, and in consequence, HIPCs would face the same pressures insurers do now, to screen out high risk applicants and keep their prices low. (The best-known prototype voluntary HIPC, Cleveland's Council of Small Enterprises (COSE), excludes some high risk groups.)

Thus many proposals instead call for a single HIPC in a geographic area, such as part of a State. (Determining the size of the area requires balancing the need for reasonably uniform costs against the need for a large enough HIPC to operate effectively.) HIPC participation by at least some classes of purchasers would be mandatory. For example, businesses up to a certain size might be required to purchase coverage through the area HIPC, while larger employers could buy coverage outside it or self insure (pay employees' claims directly instead of paying premiums to a insurer). Some argue that larger firms have the resources to do their own plan evaluation and bargaining without the HIPC. In addition, firms operating in multiple HIPC areas would prefer to offer uniform benefits rather than deal through multiple HIPCs. There is a question whether firms not required to join the HIPC could be allowed do so voluntarily. Some would exclude them on the grounds that only firms with above-average costs would do so, thus driving up HIPC premiums and, in effect, compelling small firms to subsidize high risk larger firms.

**Accountable health plans**. HIPC participation would be limited to what are frequently termed accountable health plans (AHPs), those that meet certain minimum standards. Some proposals would have a Federal board develop the standards and certify eligible plans, while others would leave this function to the HIPC. AHPs would have to demonstrate solvency and comply with standards for non-discrimination in enrollment and rating. At least at the outset, AHPs would not have to be HMOs or other managed care plans, although managed competition proponents assume that these types of plans are most likely to survive the pressures of the market. Instead, AHPs would have to furnish information, specified by the Federal board or the HIPC, relating to use and costs of services and outcomes of medical care. This information is central to the HIPC's function of furnishing comparative cost/quality data to consumers. The nature of this information has not been fully specified, and it is not clear that many plans (whether HMO or indemnity) could currently furnish the detailed data contemplated. Proponents of managed competition expect that data standards would become more stringent over time; ultimately smaller insurers would be unable to meet them, leading to greater industry concentration.

A key issue is whether the HIPC must accept any plan meeting AHP standards, or whether it may exercise discretion and select a limited number of plans. Arguments for a limited number of plans include the potential for economies of scale, easier comparisons for consumers, and perhaps allowing the HIPC to deal with quality issues and other emerging problems more rapidly and informally than would be possible in a system with more plans and a stricter regulatory structure. However, proposals that mandate HIPC participation by some or all employers -- and perhaps by Medicaid beneficiaries and individual purchasers -- could mean that no insurer could operate in an area if it was not selected by the HIPC. Some people estimate that as many as 3,000 separate entities now sell health insurance in the U.S. There is likely to be considerable resistance to giving HIPCs discretionary powers to put all but five or six of these out of business. Instead HIPCs might be required to operate in a formal, quasi-governmental fashion, with market concentration occurring gradually as standards and competitive pressures grew tighter.

**Defining benefits**. Managed competition requires both the definition of a basic benefit package and a decision about what sorts of benefits may be offered over and above the basic package.

Defining this package is an important issue, since the package would constitute not only the minimum available for all participants but also the maximum for which employer contributions or public subsidies would be provided. A basic plan that would be affordable for individuals or small employers could represent a significant reduction in benefits for employees of larger firms with generous benefit plans. On the other hand, the scope of the basic plan would also determine the amount of new Federal revenues available from limiting the tax exclusion for employer benefits; a package less generous than current employee benefits would raise more money.

In most proposals, the basic package would also constitute the "free" plan for current Medicaid beneficiaries and new low-income populations receiving assistance in buying coverage. Too restrictive a basic package could deprive the poor of access to needed services; some proposals would include free supplemental benefits for persons below a given income threshold.

Whatever the basic plan consists of, there is also the issue of what may be offered over and above the basic plan (with any additional expenses to be borne by the consumer). As noted earlier, some proposals would require an AHP to sell the basic plan and nothing else, on the grounds that benefit variations make price comparison difficult, and that some benefit packages could be designed by insurers to attract low-risk enrollees and deter high-risk ones. Under these proposals, variation among plans would be limited to "amenities." This term is ill-defined; amenities could conceivably include, not just personal comfort items, but also greater access to medical technology, shorter waiting times for services, and higher quality care. The result could be the evolution of different levels of access and quality for different income groups. This issue is considered further below.

Finally, there is the question of whether individuals purchasing basic coverage through the HIPC could separately purchase supplemental coverage, for example to meet deductible and coinsurance requirements under the basic plan. While the competitive approach would not necessarily rule out individuals' buying additional coverage with their own after-tax dollars, persons with supplemental coverage might use more services under the basic plan than persons without this coverage (because they would not have the deterrent of cost-sharing). Price comparisons among basic plans might be distorted if some plans' enrollees were obtaining care financed through supplemental coverage.

**Risk adjustment**. As noted earlier, most proposals call for some form of risk adjustment to correct for biased selection, including both self-selection (preference of high-risk patients for certain plans) and "skimming" (deliberate measures by plans to attract low-risk enrollees). The HIPC would collect premiums due to each plan (including employer, public, and/or individual contributions) and would then adjust the amount to reflect the actual level of risk represented by each plan's population. This is meant to ensure that plans compete on the basis of efficiency, rather than on their ability to attract low-cost enrollees.

Risk adjustment requires measures that can reliably predict the relative need for health services of the membership of different plans on the basis of readily collectible information about member characteristics. The simplest measures are demographic characteristics such as age and sex. There have also been experiments with the use of other kinds of data, including a review of past diagnoses or services received and questionnaires on self-perceived health status. At an individual level, age and sex have been found to predict only 1-4% of differences in health utilization. Systems using diagnosis or service data do only somewhat better, predicting up to 8% of utilization; however, most have been tested on Medicare populations and might not function as well for younger populations with less chronic illness. Some proponents of managed competition contend that, if HIPC areas are large enough and there are only a few AHPs in each HIPC, plan populations may be large enough that even relatively crude measures (such as age, sex, and a brief health questionnaire) would permit adequate plan comparison.

**Plan capacity**. A central concept of managed competition is that every individual in the HIPC can choose the most efficient plan for the base price or can pay more for a less efficient plan. However, the plans that are hypothetically most efficient -- staff and group model HMOs -- also have a limited short-term capacity to accept new members, because they must develop new facilities and hire additional personnel when their enrollment grows. This could mean that many HIPC participants would not in fact have the option of joining the lowest cost plan. If, for example, the District of Columbia Medicaid program bought coverage through the local HIPC and the low-bidding plan was one of the group model HMOs, there might be 100,000 beneficiaries seeking to join an HMO that could accept only 5,000 or 10,000, because all other options would require out-of-pocket payment. This is an extreme case, but it is possible that there will be always be areas in which the lowest cost plan cannot accept everyone who wishes to join it. Participants might then be allowed to join the next least costly plan without additional out-of-pocket costs (and so on until there were enough base price slots for everyone who wanted one). However, this solution would weaken price competition and could limit potential savings until capacity problems could be solved.

**Imperfect competition**. Many parts of the country still have no HMOs or other network plans, and there are areas in which development of competing provider networks may not be feasible (for example, a rural town with a single physician). Some proposals define these "areas of imperfect competition," those that may be temporarily or permanently unable to support true competition among plans and whose populations are likely to continue in traditional indemnity coverage. Over time, there might be relatively few such areas. As of 1989, however, there were still 12 States in which fewer than 5% of the insured population was in HMOs. Pending development of competing plans, some proposals would use other cost controls in these areas, such as price or premium regulation. This solution, however, moves from a competitive to a regulatory approach, and raises the problem of deciding just when an area has sufficient competition to shift back from the regulatory to the market approach to cost control.

**Income tiering**. Managed competition proponents argue that the power of the market would compel all plans to make steady improvements in both quality and efficiency. However, if the health care market could be induced to evolve in the same way as other markets, it is not necessarily the case that the end product would be a single class of plans uniformly striving to achieve the same goals. The health care market might instead be segmented in the way that the markets for other goods and services are: there might be economy and luxury health plans, with different levels of access and quality, just as there are economy and luxury automobiles. Access to care varies by income level in the current system; so long as everyone was assured basic coverage of adequate quality, it might not be a concern that access disparities would continue in a competitive system. However, some proposals do seek to reduce the possibility that there might develop low-income and high-income health plans.

One proposal for limiting tiering is to require that every plan accept a specified number of low-income persons at the base rate; this would require some system for deciding who would be allowed into the higher-priced plan and who would be required to accept the free plan. An alternative, included in the Garamendi plan, is to place a dollar or percentage limit on the amount by which any plan's premium could exceed the base rate. This would limit the range of quality differences among plans.

## Major Proposals

**Jackson Hole Group**. The Jackson Hole Group is an informal group of health policy experts and other interested parties led by Paul Ellwood, Alain Enthoven, and Lynn Etheredge; the group's health reform proposal was first issued in 1991. Under the general oversight of a National Health Board, each State would designate one or more HIPCs that would contract with Accountable Health Partnerships (AHPs). AHPs would be provider or provider-insurer networks that were approved by the national board and that (a) agreed to provide a uniform benefit package approved by the board to all firms or individuals and (b) provided outcome data specified by the board to allow comparison of quality among AHPs.

All employers would be required to contribute to the cost of health benefits for full-time employees and pay a payroll tax on behalf of part-time employees. Firms with fewer than 100 employees would obtain coverage through the HIPC; larger firms could deal with AHPs on their own. The current exclusion of health benefits from employees' income would not apply to non-AHP plans or to any employer contributions in excess of the lowest price offered by an AHP through the area HIPC for the standard benefit package. Employees wishing a more costly plan would pay the difference themselves. Part-time workers and others not obtaining coverage through their employer would obtain coverage through the HIPC. The State would pay the premium for the lowest-cost plan on behalf of Medicaid beneficiaries and would subsidize all or part of the premiums for other low-income persons. Eventually Medicare would also purchase coverage through HIPCs.

**Conservative Democratic Forum (CDF)**. The CDF plan, introduced in the 102nd Congress as H.R. 5936 (Cooper), is conceptually similar to the Jackson Hole proposal, but differs in several key details. Employers would not be required to furnish health coverage. Small employers (those with up to 1,000, or at State option up to 10,000 employees) who chose to offer coverage would have to purchase through the HIPC. Employer contributions in excess of the lowest AHP price would not become taxable income to the employee, but the employer would be subject to a 34% excise tax on excess contributions or any contributions to a non-AHP plan. (Self-insured plans could continue to operate if they met AHP standards.) Basic plan costs would be fully deductible for individuals. Medicaid would be phased out, with the acute care component replaced by Federal premium and cost-sharing subsidies for low-income persons covered through HIPCs; States would be responsible for long-term care. Financing for low-income subsidies would include the excise tax on excess contributions and elimination of the current ceiling on wages subject to the Medicare payroll tax.

**Senator Bingaman**. Senator Bingaman introduced three managed competition bills in the 102nd Congress: S. 2675, S. 3165, and S. 3300. The last of these is the most comprehensive. It would create an HIPC/AHP structure comparable to that in the Jackson Hole and CDF proposals. All U.S. residents would be eligible for coverage through State-established HIPC programs. Federal contributions to the State programs would cover an average of 75% of the cost of coverage, with the remainder financed through individual premiums (subsidized for low-income persons) and optional employer contributions. The Federal grants would be subject to budget limits based on projected national average per capita costs for AHP coverage; States not able to provide coverage within the limits would have to supply additional resources. No employer could offer a plan outside the HIPC; current self-insured plans could be offered through the HIPC but apparently could not be restricted to the employer's own workers.

**Garamendi plan**. In February 1992, California Insurance Commissioner John Garamendi proposed a universal coverage plan to be implemented at the State level. The California legislature approved legislation to plan for implementation of the proposal; this legislation was vetoed by Governor Wilson. Under the Garamendi plan, the State would establish one HIPC for each geographic area; virtually all persons in the State would obtain uniform coverage through the HIPC. Medicaid and perhaps Medicare would be incorporated in the system if Federal waivers could be secured. The State would pay the premium for the lowest-priced plan on behalf of all residents, with the costs to be funded through employer and employee payroll taxes. The State contribution could not exceed per capita revenues from the payroll tax; this would in effect cap the premium for the low-price plan. Individuals choosing a higher-priced plan would pay the excess premium themselves. However, there would be at least two health plans available for no additional premium, and there would be a limit on the amount by which any plan's premium could exceed the base price. (One novel feature of the plan, not directly related to managed competition, is "24-hour coverage." Health payments by sources other than health insurance, such as workers' compensation or automobile insurance, would be folded into the health plan.)

**Fee-for-service default proposals**. Some proposals would extend coverage to all U.S. residents through a universal public program (whether Federal or State), but would give enrollees the option of selecting a managed care alternative. These include H.R. 5514 (Dingell/Waxman) and S. 1446 (Kerrey) in the 102nd Congress. Coverage in the standard fee-for-service plan would be free; managed care plans would also be free, but could offer more extensive benefits or reduced cost-sharing. This way of incorporating managed care is more or less the inverse of competitive proposals, in which benefits do not vary among plans and enrollees must pay extra for a fee-for-service plan.

## Potential Savings

**Overall savings.** Managed competition -- in the sense of a regulated market with strong consumer incentives to choose cost-effective plans and adequate information for evaluating those options -- has never been tried. Most large employers have offered two or more choices of health plans for many years, and some (like the Federal Employees Health Benefits Program, FEHBP) have offered a wide menu of fee-for-service, HMO, and other managed care plans, with significant differences in required employee cost sharing depending on choice of plan. However, few of these multiple choice systems meet all the criteria specified by managed competition advocates as necessary for program success. Employer contributions are not necessarily fixed at the cost of the lowest-priced plan, benefits under different choices are not uniform, reliable quality information is not made available to enrollees, and no corrections are made for biased selection. Medicare and many State Medicaid programs have also offered choices between traditional coverage and HMO enrollment; however, beneficiaries have had little or no financial incentive to accept the restrictions of HMO coverage. (Some States have mandated Medicaid HMO enrollment for some beneficiaries, instead of using the competitive approach.)

In short, there is little experience to indicate whether the market restructuring proposed by supporters of managed competition would in fact induce most consumers voluntarily to select HMOs or other hypothetically more cost-effective health plans, or whether many would pay larger premiums to retain freedom of choice of providers. Assuming, however, that consumers would in fact select some form of managed care plan, would these choices result in overall cost savings? Evidence on the efficacy of HMOs and other managed care plans has been reviewed at length elsewhere, most recently by the Congressional Budget Office (CBO) (see For Additional Reading). The following is a brief summary of what is known.

-- Staff and group model HMOs -- those that employ or contract with physicians who exclusively treat HMO enrollees in HMO-operated facilities -- have been shown in the past to achieve savings of up to 25% relative to completely uncontrolled indemnity plans. As noted earlier, most indemnity plans now use at least pre-admission review of inpatient stays. For this and other reasons, CBO estimates that staff and group model HMOs might now save 15% compared to indemnity plans. Individual practice associations (IPAs), which contract with physicians who treat both HMO and non-HMO enrollees in their own offices, achieve much smaller savings.

-- Newer forms of managed care plans, including PPOs and point-of-service plans, have not been systematically evaluated. Some insurers and employers have reported savings from these plans. Their savings potential may vary, depending on whether they rely solely on negotiated provider discounts to reduce costs or also engage in active management of care. Discount arrangements can produce savings for a particular purchaser; however, if the providers make up for the discounts by raising charges to other purchasers, there may be no system-wide savings. Plans that also include utilization review or similar measures may have a greater net effect.

-- HMOs appear to achieve a one-time savings, relative to fee-for-service plans, but may not reduce long-term growth in health care costs. For example, over the period 1970 to 1990 per member revenues of the Kaiser Foundation Health Plans, the largest and one of the best-established HMOs, rose at an annual rate of 11.5%. National per capita spending for services equivalent to those offered by Kaiser rose at an annual rate of 10.6%.

Some people say that the apparent failure of HMOs to achieve ongoing savings in the current market is the result of "shadow pricing": because the HMOs do not face real competition they need only keep their prices just below those of the indemnity plans, and have not faced pressure to operate as efficiently as they could. An alternative view is that over time HMOs face the same cost pressures as other insurers, in particular provider and consumer demand for the adoption of new medical technologies.

**Federal budget savings**. Whatever the potential of managed competition or managed care to control overall health spending, Congress is necessarily concerned with any proposal's short- and long-term impact on the Federal budget, for two reasons. First, spending on Medicare and Medicaid is among the fastest growing components of the budget; there is a consensus that control in this sector is central to any plan for deficit reduction. Second, virtually every proposal for extending coverage to the currently uninsured population requires at least some new Federal spending, whether in the form of direct subsidies or tax assistance for the private purchase of insurance or in the form of publicly provided coverage. Many in Congress would prefer to fund this new spending through offsetting savings in the health sector, rather than through new taxes, increased deficits, or diversion of resources from other government programs.

Thus, while controlling costs for employers and individuals is an important objective, it may be unlikely that a plan can be adopted unless it also generates measurable savings for the Federal Government. These savings can take two basic forms:

-- Control of direct spending for Medicare, Medicaid, and other health programs (such as the Federal Employees Health Benefits Program).

-- Control of tax expenditures; that is, reducing the loss of Federal revenues resulting from tax-favored health spending, chiefly on employee benefits.

Most proposals would temporarily or permanently exempt Medicare beneficiaries from participation in a managed competition system, at least in part because beneficiaries, many of whom may have long-standing ties with particular physicians or other providers, are likely to resist a change to new health systems. On the other hand, most proposals would eliminate the acute care component of Medicaid, replacing it with some form of subsidy to help current beneficiaries and other low-income persons buy coverage through a HIPC. Assuming that current beneficiaries would receive a full premium subsidy for the basic plan, along with waiver of any cost-sharing requirements, it is not certain what net Federal savings would result. As suggested earlier, capacity problems make it unlikely that all beneficiaries could be promptly shifted to the most efficient managed care arrangements. Even if they could, savings might be limited, because Medicaid in most States is already paying providers less than their actual costs or usual charges. CBO has estimated that enrollment of all Medicaid beneficiaries in staff or group model HMOs would have saved a maximum of $3.5 billion in 1990 (or about $2 billion in Federal funds).

For the most part, then, Federal savings would have to take the form of reduced tax expenditures. CBO projects a Federal 1992 revenue loss of $39.8 billion from the exclusion of employer-paid health insurance from employees' income. Assuming that the least costly HIPC in every area would be 15% below typical current plan premiums -

- the maximum CBO savings estimate for staff/group HMOs -- maximum potential new revenues from taxing excess employer contributions would be about $6 billion. The actual amount would be somewhat less, because most employers are not now contributing the full costs of employee coverage and because some excess contributions might be converted to other forms of nontaxable fringe benefits.

**Budget control options.** The maximum savings assumptions from managed competition assume that the entire population would promptly join the most efficient types of managed care plans. As a practical matter, this is not an immediate option for most of the population. Staff/group model HMOs or similarly closely organized plans are unavailable in many areas and will take time (and capital) to develop; where they exist, time will be needed to expand capacity. Because there is growing pressure to achieve some immediate control over health spending, some people who believe that competition is ultimately the best approach are now endorsing regulatory spending limits as a sort of interim or fallback measure. Discussion of this option is just beginning, and few detailed proposals yet exist. So far, at least three approaches have been suggested:

-- Rate of increase limits for premiums. No insurer could raise premiums beyond a specified maximum annual increase.

-- Absolute per capita premium limits. No insurer could charge more than a specified maximum amount for a defined basic package of benefits.

-- Budget targets. A desired rate of growth in national health spending would be established as a benchmark. Only if managed competition failed to achieve the desired savings would the budget target be enforced (through premium regulation or direct regulation of provider prices).

The Garamendi plan (and any plan with a defined revenue source) would limit costs in a different way. The amount collected in payroll taxes defines the amount available to pay for the least costly AHP. Thus the State contribution for HIPC coverage cannot rise faster than wages. (However, if insurers cannot hold their cost increases at this level, there might be no "free" plan available, or the minimum benefits might have to be curtailed.)

## FOR ADDITIONAL READING

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# Prescription Drug Prices: Should The Federal Government Regulate Them?

## SUMMARY

A sharp escalation in the rate of increase in prescription drug prices since the early 1980s, coupled with the high and rising initial prices charged by manufacturers for new breakthrough drugs in recent years, sparked a lively debate in the 102nd Congress over whether the Federal Government should regulate prescription drug prices.

The price increases, which have led to a twofold rise in the Consumer Price Index for Prescription Drugs since 1983, appear to have contributed to a large increase in pharmaceutical industry profits. During the 1970s, when drug prices rose less than the general price level, the drug industry earned an average return on stockholders' equity (after taxes) of 18.4%. But in the 1980s, when drug prices rose faster than the general price level, the industry's return rose to 21.2%.

No single factor accounts for this increase in drug price inflation. Rather, the explanation lies in the dynamic interplay of a host of factors, some of which took root before the 1980s. By most authoritative accounts, the key ones have been a progressive shortening of the period when a drugmaker can expect to earn monopoly profits on a drug and continuing increases in the cost of developing, testing, and marketing new innovative drugs. One effect of these trends has been to step up the pressure on pharmaceutical firms to squeeze as much profit as possible from a drug while it is protected by a patent.

Those who favor Federal regulation of prescription drug prices say prices should be controlled because the recent surge in prices has severely strained the budgets of the biggest users of prescription drugs -- the elderly and the chronically ill -- and because the pharmaceutical industry has used most of the higher profits generated by the price increases to develop duplicative -- or "me-too" -- medications and to undertake costly marketing campaigns.

Opponents of Government regulation of prescription drug prices counter that any restrictions on the ability of pharmaceutical firms to set their prices would undercut the most potent incentive for investment in new drug development: the prospect of earning a return on investment consistent with the high costs and risks involved in such an enterprise. They also point out that even with the rapid climb in drug prices in recent years many drug therapies are still much cheaper than alternative treatments, such as surgery and psychotherapy.

A number of bills to restrain prescription drug prices were introduced in the 102nd Congress. Some were intended to offset the higher drug costs for Federal agencies and health insurance programs which are related to a 1990 Federal law mandating drug price rebates under the Medicaid program. None of the bills, however, would have imposed comprehensive controls on the prices manufacturers could charge.

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## ISSUE DEFINITION

Sharp increases in the prices for a wide range of branded (or brand-name) prescription drugs since the early 1980s, coupled with the high and rising initial prices charged for a number of innovative drugs in recent years, sparked a heated debate in the 102nd Congress over controlling drug prices. A number of bills to restrain drug price inflation -- especially as it affected Federal spending on prescription drugs -- were introduced. The crux of the issue for that and the next Congress lies in striking a balance between the importance of allowing pharmaceutical firms sufficient financial incentive to keep supplying existing drugs and investing in the development of new, more effective ones, and the insistence of most people -- especially the elderly and chronically ill -- on having unlimited and affordable access to needed medicines.

## BACKGROUND AND ANALYSIS

Unlike the 1970s, prescription drug prices have risen much faster than the general price level since 1980 (see **table** 1). Between 1980 and 1985, the Consumer Price Index (CPI) for prescription drugs, which is a gauge of price change for these drugs at the retail level, went up at an average annual rate of 10.6%, compared to 5.5% for the CPI for all items; and from 1985 to 1991, the CPI for prescription drugs increased at an average annual rate of 8.9%, compared to 4.0% for the overall CPI. Also unlike the 1970s, prescription drug prices have gone up faster than the overall cost to consumers of medical care since the early 1980s. Largely as a result, the share of total U.S. spending on health care accounted for by producer sales of prescription drugs increased from 4.5% in 1980 to an estimated 5.5% in 1990.

Since the 1970s prescription drug prices have also risen faster than consumer incomes: from 1980 to 1991, the CPI for prescription drugs went up at an average annual rate of 9.6%, compared to 6.2% for U.S. per-capita disposable income, measured in current dollars. This disparity suggests that the average consumer has had to give up an increasing share of his or her income to buy needed drugs.

It appears that the vast share of the increase in prescription drug prices over the past decade is due to price hikes for branded drugs -- both those still protected by a patent (i.e., single-source drugs) and those whose patent has expired (i.e., multiple-source originator or innovator drugs). According to a 1990 study by Joseph Thomas and Stephen Schondelmeyer of the School of Pharmacy at Purdue University, a retail price index they constructed for 104 of the most commonly prescribed drugs for the elderly rose at an average annual rate of 7.2% from December 1981 to December 1988. By contrast, the price index for all single-source drugs in the sample rose at a rate of 7.4%; that for all multiple-source originator drugs, at a rate of 8.4%; and that for all generic drugs, at a rate of 2.7%. Generic drugs, which are the biochemical equivalent of branded drugs, tend to be much lower in price for two reasons. One is that, largely as a result of the Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417), it costs far less to bring generic drugs to the market; and the second is that there are no patent barriers to entering the market for these drugs.

**TABLE 1. Change in U.S. Disposable Personal Income, General Price Level, and Prescription Drug Prices: 1980 to 1991**
(Percent Change from Previous Year)

| | Disposable Per-Capita Personal Income (%) | Consumer Price Index (CPI) for All Items (1982-84=100) (%) | CPI for Medical Care (1982-84=100) (%) | CPI for Prescription Drugs (1982-84=100) (%) |
|---|---|---|---|---|
| 1980 | 10.1 | 13.5 | 9.6 | 9.2 |
| 1981 | 10.2 | 10.3 | 10.7 | 11.4 |
| 1982 | 5.6 | 6.2 | 11.6 | 11.6 |
| 1983 | 6.5 | 3.2 | 8.7 | 11.0 |
| 1984 | 9.7 | 4.3 | 6.2 | 9.6 |
| 1985 | 5.7 | 3.6 | 6.3 | 9.5 |
| 1986 | 5.4 | 1.9 | 7.5 | 8.6 |
| 1987 | 4.1 | 3.6 | 6.6 | 8.0 |
| 1988 | 9.6 | 4.1 | 6.5 | 7.9 |
| 1989 | 5.8 | 4.8 | 7.7 | 8.7 |
| 1990 | 6.0 | 5.4 | 9.0 | 10.0 |
| 1991 | 2.8 | 4.2 | 8.7 | 9.9 |

Sources: U.S. Department of Commerce, Bureau of Economic Analysis, and U.S. Department of Labor, Bureau of Labor Statistics.

## Drug Price Increases and Pharmaceutical Industry Profits

The escalation in drug prices over the past decade has helped boost the profitability of the pharmaceutical industry. From 1970 to 1980, when the general rate of inflation was 81% higher than the rate of drug price inflation, the average return on sales (after taxes) in the drug industry came to 10.5% and the average return on stockholders' equity (after taxes) to 18.4%. However, from 1980 to 1990, when prescription drug prices increased more than twice as fast as the general price level, the drug industry earned an average after-tax return on sales of 13.0%, and an average after-tax return on equity of 21.2% (see **Table 2**). In 1991, the industry's return on sales was 15.2%, and its return on equity 26.0%. This increase in profitability also reflects the efforts by many U.S. pharmaceutical firms since the early 1980s to cut their operating costs, especially by exploiting the economies of scale in marketing and research and development (R&D) made possible by a spate of mergers and joint ventures.

Traditionally, the drug industry has earned a higher return on investment than most other industries. For example, during the 1970s, the average after-tax return on stockholders' equity was 18.4% in the drug industry, compared with 12.8% for all manufacturing industries. The escalation in drug price inflation since the early 1980s has helped widen the gap. From 1980 to 1990, the average after-tax return on equity for the drug industry was 21.1%, and for manufacturing 11.9%. While many factors account for the relatively high profitability of the drug industry, two of the more important are the patent protection given new drugs, and the high risk of failure in commercializing drug compounds synthesized in the laboratory, which predisposes investors to seek above-normal returns on their equity investments in pharmaceutical firms.

### TABLE 2. Profitability of the U.S. Manufacturing Sector and the Pharmaceutical Industry: 1980 to 1991

| | Return on Stockholders' Equity, After Taxes (%) | | Net Income, After Taxes (1980=100) | |
|---|---|---|---|---|
| Year | Drugs | Manufacturing | Drugs* | Manufacturing |
| 1980 | 19.9 | 14.0 | 100.0 | 100.0 |
| 1981 | 16.9 | 13.7 | 90.7 | 108.8 |
| 1982 | 19.7 | 9.3 | 119.0 | 76.2 |
| 1983 | 20.3 | 10.6 | 132.5 | 92.0 |
| 1984 | 20.2 | 12.4 | 143.2 | 115.6 |
| 1985 | 15.2 | 10.1 | 143.0 | 94.3 |
| 1986 | 22.9 | 9.6 | 159.2 | 88.8 |
| 1987 | 17.4 | 12.7 | 192.5 | 124.0 |
| 1988 | 30.4 | 16.0 | 235.6 | 166.0 |
| 1989 | 28.0 | 13.7 | 265.7 | 146.3 |
| 1990 | 27.1 | 10.7 | 335.5 | 118.9 |
| 1991 | 26.0 | 6.5 | 380.3 | 72.9 |

* This index is based on the combined net income in each year of the following companies: Abbott Laboratories, American Home Products Corp., Bristol-Myers Squibb Co., Johnson & Johnson, Eli Lilly & Co., Merck & Co., Pfizer Inc., Schering-Plough Corp., SmithKline Beecham Corp., Syntex Corp., Upjohn Co., and Warner-Lambert Co.

Sources: Standard & Poor's Corp. Industry Surveys: Health Care: Basic Analysis (various issues), and U.S. Department of Commerce, Bureau of the Census. Quarterly Financial Report (various issues).

## Prescription Drug Price Increases and the Elderly and Chronically Ill

Much of the furor over recent prescription drug price hikes has focused on their impact on the elderly and the chronically ill. There is reason to believe that these groups bear a disproportionately large share of the rise in prescription drug prices and are suffering great hardships as a result.

The elderly are the largest users of prescription drugs among major age groups. According to a 1990 study by the School of Pharmacy at Purdue University, those age 65 and over represented 12.4% of the population in 1988 but accounted for 34.3% of retail spending on prescription drugs. And the U.S. Bureau of Labor Statistics reports that in 1989, the average American consumer spent $240 on drugs -- both prescription and over-the-counter -- but the average person age 65 or over spent $428. Furthermore, the incomes of the elderly tend to be much lower than other adults, and they are much more likely to pay the full cost of prescription drugs. According to figures compiled by the U.S. Bureau of the Census, the median income in 1990 for households whose chief owner or renter was 65 years of age or older was about one-half the level for all other households: $16,855 versus $33,920. And a 1990 report by Thomas and Schondelmeyer of the School of Pharmacy at Purdue University found that in 1988 households whose reference person was 65 years or older spent "almost three times as much" of their own money for prescription drugs as all other households. The Health Care Financing Administration reports that for Americans of all ages, out-of-pocket funds accounted for 55%, private health insurance for 26%, and public health care programs -- mostly Medicaid -- for about 19% of retail prescription drug purchases in 1990.

## Drug Price Increases: Underlying Causes

No single factor explains the escalation in prescription drug price inflation since the early 1980s. Rather, it appears that the explanation lies in the dynamic interplay of a number of trends, many of which started before the 1980s. Six in particular have exerted a powerful influence over recent pricing patterns:

-- (1) the increased vulnerability of sellers of branded prescription drugs to competition from cheaper generic substitutes as a result of the Drug Price Competition and Patent Term Restoration Act of 1984;

-- (2) moves by increasing numbers of large buyers of and third-party payers for prescription drugs to set maximum reimbursement levels for certain classes of drugs and to restrict coverage of drug expenses to a list of approved drugs, many of which are generic substitutions;

-- (3) an apparent sharp rise in the cost of developing and gaining marketing approval for new drugs since the late 1970s;

-- (4) the growing reliance of pharmaceutical firms on costly marketing campaigns -- mainly directed at physicians but increasingly at consumers -- as a vehicle for protecting or expanding market share;

- (5) a slowdown in the rate of growth in domestic demand for prescription drugs during the 1980s; and

- (6) a steady but gradual erosion of the period when a new, pioneering drug faces no competition from other patented drugs offering comparable therapeutic benefits.

In combination, these forces have increased the pressure on the pharmaceutical industry to obtain as much profit as possible from drugs during the period they are protected by a patent. The industry has sought to do this largely by aggressively increasing prices for existing drugs and charging high initial prices for newly approved drugs. As a result of the Drug Price Competition and Patent Term Restoration Act of 1984, the effective patent life of a drug developed after 1984 can stretch to a maximum of 14 years -- out of a possible 17 years. Arguably, by raising prices for patented drugs rapidly, pharmaceutical firms are trying to achieve three aims at once: (1) recouping their huge investments in developing and marketing drugs; (2) raising the even larger sums of money needed to search for new highly successful drugs; and (3) insuring that stockholders receive an adequate return on their investments. Because the demand for many prescription drugs tends to respond little (if at all) to changes in price and makers of patented drugs face little or no effective competition for those drugs, an increase in the price of such a drug is likely to raise the producer's operating profits.

## Arguments in Favor of Regulating Prescription Drug Prices

Many critics of recent pricing trends in the pharmaceutical industry favor imposing some kind of Federal regulation on the ability of manufacturers to set their own prices. Four arguments commonly are advanced to support this position.

**1. Price Increases Have Made Many Needed Drugs too Costly for the Largest Groups of Users:** This argument addresses the social welfare or equity effects of drug price increases. Critics claim that two of the largest groups of users of prescription drugs -- namely, the chronically ill and the elderly -- are least able to afford the recent climbs in prices, as well as the high initial prices being charged for a host of breakthrough drugs. Compared to the average working adult, their incomes are likely to be lower and their purchases of prescription drugs less likely to be covered by public or private health insurance. Critics also point out that continued rapid increases in drug prices eventually will hurt all consumers by forcing public and private health insurers to raise premiums and copayments. Price controls, it is argued, are needed to insure that everyone has unrestricted, timely, and affordable access to the drugs they require.

**2. Price Increases Have Been Intended Mainly to Boost Profits:** Critics charge that the sharp hikes in drug prices over the past decade have been intended primarily to boost the profits of pharmaceutical firms, not to cover increases in the cost of developing, testing, and marketing new drugs as some industry executives maintain. To back this charge, they cite the large increases in pharmaceutical industry profits in the 1980s (see **table 2**). (It is worth noting that as a matter of standard accounting practice these increases allow for the industry's spending on R&D and marketing, which is considered a current cost of doing business and thus is deducted from total revenues in computing net income.)

**3. Profits From Higher Prices Have Been Used to Develop and Market "Me-Too" Drugs**: A third argument raised by some proponents of Government regulation of prescription drug prices concerns what the pharmaceutical industry has done with its increase in profits. They contend that the vast share of new prescription drugs introduced in the United States is intended to compete with existing drugs in a given therapeutic class. At a hearing held by the Senate Special Committee on Aging in July 1989, Senator Pryor stated that "for every breakthrough product they invent, American drug companies bring 24 drugs to the market that provide little or no therapeutic gain over already-marketed drugs." Moreover, these same critics accuse pharmaceutical firms of plowing most of their profits into augmenting their marketing and sales efforts. Therefore, it is argued, unless the Federal Government restricts the ability of producers to raise prescription drug prices, the industry will pour ever larger sums of money into developing and marketing so-called "me-too" drugs.

**4. U.S. Consumers Subsidize Pharmaceutical R&D for Most Other Nations**: Some contend that prescription drug prices should be controlled so that American consumers no longer are forced to pay for a disproportionate share of worldwide pharmaceutical R&D and marketing. In the view of these critics, the fundamental reason for this tendency is that the United States remains the only major national market where sellers of prescription drugs are free to set their own prices. As a result, it is argued, drug prices tend to be higher in the United States than other major geographic markets. One effect of these disparities is that U.S. consumers subsidize the research and marketing done by the pharmaceutical industry in major national markets where prices are controlled, especially Canada, Japan, and the European Community (EC).

## Arguments Against Regulating Prescription Drug Prices

Opponents of Federal price controls on prescription drugs -- especially brand-name ones -- raise at least four arguments in defense of their position.

**1. Pharmaceutical Innovation Is Costly and Risky**: This argument concerns the substantial costs and risks associated with bringing new drugs to the market. Various studies have estimated that these costs have risen substantially since the early 1960s. According to a 1990 study by the Center for the Study of Drug Development at Tufts University, the pre-tax average total cost of developing and gaining FDA approval for a new drug is $231 million (in 1987 dollars); this estimate includes both the opportunity costs of the money tied up in developing new drug compounds -- both those that fail and those that succeed -- and the direct costs to companies of compounds that fail to win FDA approval. In addition, the odds against commercializing a new drug compound are very large: industry estimates of the chances of successfully commercializing a compound synthesized in a research laboratory range from one in four thousand to one in ten thousand.

Opponents of Federal regulation of prescription drug prices argue that price controls would be likely to keep drug companies from earning a return on their investments in research and development that is consistent with the huge costs and risks they must bear. And if this were to happen over a long period, it is feared, pharmaceutical firms eventually would respond by slashing their spending on R&D.

Sustained cutbacks in R&D spending, it is claimed, would eventually diminish the flow of new breakthrough drugs from the laboratory to the marketplace.

**2. Drug Therapy Is Often Much Cheaper Than Alternative Treatments**: Opponents of price controls on prescription drugs also argue that such controls could prove counterproductive in the long run. The reason is that innovations in drug therapy can and do lower the Nation's bill for health care. The Pharmaceutical Manufacturers Association (PMA) maintains that despite the price increases and the high initial prices for many new breakthrough drugs approved since the early 1980s, prescription drugs continue to offer the most cost-effective of the available therapies (including surgery or psychotherapy) for a number of disorders. For example, it points out in the 1991 edition of its Statistical Fact Book that the cost of using drugs to treat ulcers runs from $200 to $500 a year, but the cost of ulcer surgery ranges from $7,200 to $14,500. Moreover, a 1990 study by the Battelle Medical Technology and Policy Research Center -- which was sponsored by the Schering-Plough Corporation -- estimated that between 1990 and 2015, expected advances in drug therapy for heart disease alone could save $211 billion in health care costs and prevent five million deaths and another nine million new cases.

**3. Competition Is the Most Efficient Way to Restrain Drug Prices**: A third argument against regulating prescription drug prices is that unfettered competition, not Government regulation, is the most efficient way in the long run to restrain price increases and push them down to the level of lowest average cost. And opponents of such regulation contend that the pharmaceutical industry has long been highly competitive. According to data compiled by the U.S. Bureau of the Census, the four largest U.S. makers of pharmaceutical preparations accounted for 22%, the eight largest for 36%, the twenty largest for 65%, and the fifty largest for 88% of U.S. shipments in 1987, the most recent year for which figures are available. These figures suggest that the structure of the industry is not perfectly competitive. More specifically, it can be subdivided into two levels: at one level are clusters of firms (innovative and generic) competing in the same class of drugs by selling products that may differ in price or therapeutic effects or both, and at the other level are firms selling patented drugs and earning monopoly profits.

**4. Price Controls Would Undermine the Competitiveness of U.S Pharmaceutical Firms**: Some opponents of regulating prescription drug prices contend that controlling prices will weaken the international competitiveness of U.S.-based pharmaceutical firms. Controls will lead to lower prices in the long run, and lower prices would also lead to lower revenues in the long run as the demand for drugs is insensitive to price changes. If revenues fall or rise more slowly, companies would have less money to invest in R&D, all other things being equal. Cuts in R&D spending carry a high risk of slowing the rate of introduction of new drugs, and new drugs are the mainspring for growth in the pharmaceutical business. In a 1991 report on the international competitiveness of the U.S. pharmaceutical industry, the U.S. International Trade Commission concluded that the "high degree of competitiveness" shown by the industry during the 1980s can be traced to its stunning success in developing new products that generated huge revenues throughout the world from 1975 to 1989.

## Drug Price Rebates Under Medicaid

Since 1938 the Federal Government has regulated the safety of drugs sold in the United States, and since 1962 it has required that all new drugs meet certain stringent standards of efficacy before they can be approved for use. But until the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) was signed into law on Nov. 5, 1990, the Federal Government made no effort to force drug firms to reduce their prices in any of the markets they sell in.

The Federal role in pharmaceutical industry pricing changed markedly on Jan. 1, 1991. Beginning that day, companies selling prescription drugs to Medicaid recipients have had to give State Medicaid programs the same deep discounts -- sometimes as much as 60% off the average wholesale price -- they traditionally offered other large buyers, such as VA hospitals and health maintenance organizations (HMOs). These discounts take the form of periodic rebates by manufacturers for prescription drugs dispensed to Medicaid beneficiaries at retail pharmacies in all States. The new rules on drug reimbursement, which were a provision of OBRA 90, are intended to reduce Federal and State payments for prescription drugs under Medicaid, which amounted to $4.4 billion in fiscal year (FY) 1990. In late 1990, the Congressional Budget Office estimated that the rebates could save the Federal Government $1.9 billion and State governments $1.4 billion in Medicaid expenditures from FY1991 through FY1996.

Although sales under Medicaid represent between 12% and 15% of the U.S. market for prescription drugs, most industry executives strongly opposed the rebate program. They feared that the rebates would pave the way for similar Government limits on the prices charged for drugs dispensed under Medicare, which accounts for around 19% of the domestic market for pharmaceutical preparations, and eventually for drugs purchased under private health insurance plans.

Some pharmaceutical firms responded to the Medicaid rebates by reducing or eliminating the deep discounts they had been offering certain large buyers, including hospital chains, public health clinics, HMOs, and VA hospitals. In testimony at a hearing held by the House Veterans' Affairs Subcommittee on Hospitals and Health Care on Sept. 11, 1991, Anthony Principi, the Deputy Secretary of the Department of Veterans Affairs, stated that his agency expected to pay an additional $60 million for drugs in FY1991 because of the price increases sparked by the Medicaid rebates. Apart from angering supporters of the Medicaid rebates in the Congress, the efforts of the pharmaceutical industry to offset the effects of the rebates on sales spurred the introduction of a number of bills in the 102nd Congress to lower and contain the cost to various Federal agencies and programs and federally assisted entities of purchasing prescription drugs.

## Proposals in the 102nd Congress to Control Drug Prices

A number of bills to either restrain prescription drug price rises or lower the cost of prescription drugs to certain Federal agencies and health care programs were introduced in the 102nd Congress. A few were considered by the House and the Senate, and one -- H.R. 5193 -- was enacted. None of the initiatives were intended to restrict prescription drug prices at the retail level.

Of the bills considered but not enacted, one of the most controversial was S. 2000, introduced by Senator Pryor. Among other things, S. 2000 (along with its counterparts in the House: H.R. 4490 and H.R. 4594) sought to rein in drug price inflation by reducing (according to a complicated formula) the Federal income tax credit a manufacturer can earn under section 936 of the Internal Revenue Code of 1986 if it raises its prices for patented or generic drugs more than the increase in the overall Consumer Price Index. S. 2000 and its House counterparts never were reported out of the committees to which they were initially referred, but a modified version of S. 2000 was debated in the Senate in early March 1992 as a floor amendment to H.R. 4210. On Mar. 11, 1992, the amendment was rejected by a vote of 61-36.

The bill that was enacted, H.R. 5193 -- The Veterans Health Care Act of 1992 -- P.L. 102-585, combines elements from a number of other legislative proposals, including H.R. 2890 and S. 2575. Title VI of the Act sets limits on the prices that manufacturers can charge for drugs sold to various Federal agencies (including the Veterans Administration) and alters the minimum rebates for prescription drugs under the Medicaid program. The Act contains the following provisions on drug pricing:

-- the prices paid for drugs by the Indian Health Service, the VA, the Public Health Service (PHS), and clinics and hospitals receiving Federal assistance under the Public Health Service Act or the prices charged through the FSS cannot be used to calculate the "best prices" for the Medicaid drug price rebates, as of Oct. 1, 1992;

-- drug firms must make all their drugs available for purchase through the FSS;

-- drug firms are required to offer specified federally assisted clinics and hospitals (e.g., a migrant health center) at least the same discounts they must give State Medicaid programs;

-- beginning Jan. 1, 1993, drugs purchased by the VA, the Defense Department, and the PHS through the FSS or the VA depot contracting system must be sold at a minimum discount of 24% below the non-Federal average manufacturers' price; and

-- the minimum Medicaid rebates for single-source drugs and multiple-source innovative drugs become 15.7% from Oct. 1, 1992 to Dec. 31, 1993; 15.4% in calendar year 1994; 15.2% in calendar year 1995; and 15.1% in every year thereafter.

## Outlook in the 103rd Congress

In part because of pledges made by President-elect Clinton during the election campaign to enact legislation that restrains increases in the cost of health care, many think the issue of regulating prescription drug prices (especially the prices charged outside Federal programs) is likely to receive considerable attention early in the 103rd Congress. Indeed, discussions about price controls reportedly are already taking place between representatives of the pharmaceutical industry and officials of the Clinton Administration transition team. Many concerns are likely to color whatever congressional debate on the issue occurs. Some of the more pressing and problematic ones are (1) the likely impact of price controls on new drug development in the United States, (2) the link between drug pricing and the uncommonly high profits earned by drug firms, (3) the tendency of major pharmaceutical firms to spend more on advertising and promotion than on research and development, (4) the role of federally funded research in the discovery and pricing of new innovative drugs, and (5) the benefits to the pharmaceutical industry of existing Federal tax laws.

## LEGISLATION

**P.L. 102-585, H.R. 5193**

Veterans Health Care Act of 1992. Improves the delivery of health care to eligible veterans. Also limits the prices that can be charged for prescription drugs procured by the Veterans Administration (VA), Defense Department, and Public Health Service entities through the Federal Supply Schedule or VA contracting depots. Passed House by voice vote, Aug. 4, 1992 (H.Rept. 102-714, Part 1). Passed by Senate, amended, Oct. 1, 1992. House amended the Senate amendment, Oct. 7, 1992. Senate agreed to the House amendment to the Senate amendment, Oct. 8, 1992. Signed into law Nov. 4, 1992.

**H.R. 2890 (Montgomery)**

Requires the Secretary of Veterans Affairs to renegotiate the prices paid for drugs and biologicals so they do not exceed the prices paid by the Veterans Administration on Sept. 1, 1990, adjusted by expected changes in medical care costs. Also excludes the prices of prescription drugs purchased by the Federal Government from the formula for determining Medicaid drug rebates, as of Oct. 1, 1991. Introduced July 15, 1991; referred to Committees on Veterans Affairs; and Energy and Commerce. Reported by Veterans Affairs Committee Nov. 25, 1991 (H.Rept. 102-384, Part I). Reported by Energy and Commerce Committee, amended, Sept. 22, 1992 (H.Rept. 102-384, Part II).

**H.R. 3405 (Wyden)**

Public Health Clinic Prudent Pharmaceutical Purchasing Act. Amends Title III of the Public Health Service Act to require manufacturers of prescription drugs, over-the-counter drugs, and birth control devices to give rebates to clinics receiving financial assistance under this Act. Introduced Sept. 24, 1991; referred to Committee on Energy and Commerce.

**H.R. 3823 (Stark)**

Medication Price Control Act of 1991. Amends the Internal Revenue Code of 1986 to disallow the Federal income tax credit for research and development expenses for any research related to the development of medications that duplicate in medical importance or therapeutic usage one or more drugs already on the market, and for manufacturers who charge excessive prices for new drugs. Introduced Nov. 11, 1991; referred to Committee on Ways and Means.

**H.R. 4490 (Dorgan)**
Prescription Drug Cost Containment Act of 1992. Restrains prescription drug price increases by reducing a drug manufacturer's Federal income tax credits for income earned in Puerto Rico and other U.S. possessions if it raises its prices for patented and former patented drugs more than the increase in the Consumer Price Index. Introduced Mar. 18, 1992; referred to Committees on Ways and Means; and Energy and Commerce.

**H.R. 4594 (Glickman)**
BasiCare Health Access and Cost Control Act. Establishes universal access to health care and controls cost of health care by standardizing private health insurance. Restrains drug price increases by reducing the Federal income tax credit for income earned in Puerto Rico and other U.S. possessions owed to drug manufacturers who raise their prices more than the increase in the Consumer Price Index. Introduced Mar. 26, 1992; referred to Committees on Energy and Commerce; Ways and Means; the Judiciary; and Rules.

**H.R. 5556 (Stark)**
Patented Medicine Prices Review Board Act of 1992. Establishes in the Food and Drug Administration a board to regulate the prices of patented prescription drugs. Introduced July 2, 1992; referred to Committees on the Judiciary; and Energy and Commerce.

**H.R. 5614 (Slattery)**
Medicaid Prescription Drug Amendments Act of 1992. Amends Title XIX of the Social Security Act to abolish the existing "best-price" mechanism to determine rebates for outpatient drugs under Medicaid. Also requires drug manufacturers to offer discounts to the Department of Veterans Affairs. Introduced July 9, 1992; referred to Committee on Energy and Commerce.

**S. 1729 (Kennedy)**
Public Health Clinic Prudent Pharmaceutical Purchasing Act. Bars clinics funded under the Public Health Service Act from purchasing prescription drugs, over-the-counter drugs, birth control devices, and vaccines from manufacturers who have not entered into agreements with the Secretary of Health and Human Services giving certain discounts. Specifies that the discounts given these clinics should not be used by the Secretary of Health and Human Services in calculating a new "best price" for determining Medicaid drug rebates. Introduced Sept. 19, 1991; referred to Committee on Labor and Human Resources. Reported Mar. 3, 1992 (S. Rept. 102-259).

**S. 2000 (Pryor)**
Prescription Drug Cost Containment Act of 1991. Restrains prescription drug price increases by reducing a drug manufacturer's Federal income tax credit for income earned in Puerto Rico and other U.S. possessions if it increases its prices more than the rise in the Consumer Price Index. Also establishes a Prescription Drug Policy Review Commission, which would report to Congress on a number of issues, including the feasibility of creating a drug price review board in the United States, modelled after the one used by Canada since 1987. Introduced Nov. 21, 1991; referred to Committee on Finance.

**S. 2575 (Cranston)**

Veterans Health Programs Improvement Act of 1992. Requires drug manufacturers to enter into pricing agreements with the Department of Veterans Affairs, the Department of Defense, and the Public Health Service. Establishes minimum discounts for drugs purchased by the Department of Veterans Affairs. Also authorizes the Secretary of Veterans Affairs to purchase prescription drugs and biologicals for all Federal health care programs. Introduced Apr. 9, 1992; referred to Committee on Veterans. Reported, amended, Sept. 15, 1992 (S.Rept. 102-401).

**S. 2950 (Chafee)**

Amends Title XIX of the Social Security Act to repeal the use of "best price" in determining rebates for prescription drugs under Medicaid, and to raise the discounts used to determine the rebates. Introduced July 2, 1992; referred to Committee on Finance.

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# Executive Summary

**Reprinted from Health Care Spending Control: the Experience of France, Germany, and Japan. Washington, General Accounting Office, 1991. p. 2-8.**

## Purpose

For two decades, the growth of health care spending in the United States has outpaced the growth of the rest of the economy—a pattern with troubling consequences for business, consumers, and government. Persistent pressures caused by rising spending have called forth various remedies, but success in containing spending has been elusive.[1] Consequently, policymakers and analysts have sought insights from the experience of industrialized countries that appear to control spending growth better, provide universal access to health care, enjoy better health, and spend a smaller share of their national income on health care.

The Ranking Minority Member, Senate Special Committee on Aging asked GAO to report on the lessons that the United States can draw from industrialized countries that spend less on health care. The Chairmen of the Senate Governmental Affairs Committee and the Senate Special Committee on Aging later joined in this request. In response, this report (1) describes how three of these countries—France, Germany, and Japan—organize their health insurance systems, achieve universal coverage, and regulate payments to providers; (2) describes the policies used in each country to contain spending for physician and hospital care; and (3) determines whether these policies were effective in moderating the rise in health spending.

## Background

A rapid escalation in spending and a noticeable narrowing of access characterize the recent experience of the U.S. health care system. Between 1970 and 1990, the share of national income spent on health care grew by more than half: from 7.3 percent of gross national product (GNP) in 1970 to 12.3 percent in 1990; projections to the year 2000 imply a share that would most likely exceed 16 percent. Notwithstanding the high and rising level of spending, more people lack ready access to health care. Between 1979 and 1987, the number of Americans without health insurance rose by a fourth—from 29.9 million to 37.4 million.

Other industrialized countries have had more success than the United States in controlling health care spending while also providing health insurance to virtually all their citizens. For example, France, Germany, and Japan each spends a significantly smaller share of its national income on health care than does the United States (see fig. 1). The lower spending in these countries has not meant less access to basic health services or deterioration in broad measures of health status, such as life expectancy and infant mortality.

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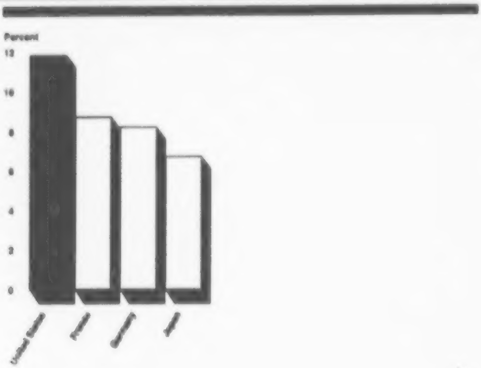
[1] The consequences of rising health spending are described in U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 7, 1991), pp. 8-11; the record of various spending control initiatives is reviewed in the same report, pp. 14-16.

Figure 1: Health Care Spending as a Share of Gross Domestic Product (1989)



This study examines the policies that have been used in France, Germany, and Japan to control health care spending. In conducting this analysis, GAO obtained data on health expenditures and health status, reviewed literature on each country's health care system, and interviewed experts from the United States and from each of the countries reviewed. GAO also analyzed the likely effects of various spending control policies and statistically estimated the effects of several policies' effectiveness. Our statistical analysis was limited to France and Germany for technical reasons.[1]

## Results in Brief

France, Germany, and Japan achieve near-universal health insurance coverage within health care systems that share three major traits with the U.S. system: (1) medical care is provided by private physicians and by both private and public hospitals, and patients have free choice of physician; (2) most people receive health insurance coverage through their workplace; and (3) health insurance is provided by multiple third-party insurers.

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[1] Unlike Japan, France and Germany made major changes in reimbursement policy during the 1970s and 1980s, those changes permitted the necessary before-and-after comparison between spending under the new policy and spending under the previous policy.

These similarities to the U.S. system coexist with several notable differences that follow from the far-reaching regulations used to guarantee coverage. First, insurers—who are predominantly non-profit—are required to provide minimum coverage that includes a wide range of health care benefits. Second, insurance enrollment is compulsory (with minor exceptions) for all residents, and they have little or no choice of insurers. Third, workplace-based insurance is financed not by premiums that reflect each individual group's expected costs of care, but largely by employer and employee payroll contributions that reflect the average cost of a larger cross section of the population.

In addition to mandating insurance coverage, all three countries standardize reimbursement rates for almost all physicians and hospitals and set ceilings (price controls) on these rates.[3] Virtually all payers must, when reimbursing providers, abide by the standardized rates. Reimbursement rates are not promulgated by the government unilaterally, but emerge from formal or informal negotiations between physicians, hospitals, third-party payers, and (in France and Japan) the government.

Budget controls—policies that augment price controls by setting limits on overall spending for hospital care or for physician services—can moderate spending growth, particularly when they are enforced. Each country sets limits on overall health spending as national goals, but only France and Germany have added policies with teeth to achieve compliance with the limits. GAO estimated that French budget controls, between 1984 and 1987, reduced real (inflation-adjusted) hospital spending by as much as 9 percent, compared with what would have been spent had price controls alone been used. Likewise, GAO estimated that for physician care services, German budget controls reduced real spending by as much as 17 percent between 1977 and 1987, compared with what would have been spent without the budget controls. By contrast, overall spending limits on German hospitals did not reduce spending growth, these limits were not, however, accompanied by a mechanism to achieve compliance.

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[3] In addition, all three countries have some controls on spending for hospital construction or the purchase of new, high-cost medical equipment.

The budget controls that successfully moderated spending growth in France and Germany are not a panacea for concerns about spending. Budget controls have not relieved all pressures on spending, in part because these controls have not been applied to all segments of the health care industry. Moreover, budget controls do not assure high-quality care or efficient delivery of services. In light of these concerns, both France and Germany are exploring modifications and supplements to their current strategies for controlling the rise in health spending.

## GAO's Analysis

### Three Countries' Health Care Systems Retain Private Medicine, Patient Choice

In France, Germany, and Japan, as in the United States, patients generally can choose their own physician; outpatient services are provided by private physicians; and inpatient care is provided in both private and public hospitals. Physicians who provide outpatient services are paid on a fee-for-service basis—as are most U.S. physicians. (Unlike in the United States, however, physicians who deliver inpatient care are often employed by a hospital on a salaried basis.)

### Countries Provide All Residents With Health Insurance Through Regulated Multipayer Systems

Each country guarantees virtually all their residents health insurance that offers a broad minimum level of benefits. Near-universal coverage is achieved by making enrollment for health insurance compulsory, with few exceptions, and virtually automatic. Health insurance is provided through a diverse mix of third-party payers that emerged from each country's particular social institutions and political history. Independent action by each payer is limited due to national regulation of enrollment, benefits, premiums, and reimbursement of providers.

### Broad Package of Benefits Is Mandated

The mandated package of health benefits covers a wide range of services. Benefits generally include coverage for physician services, hospital care, laboratory tests, prescription drugs, and some dental and optical care. Patients in all three countries do not pay deductibles for health care services; copayments for physician and hospital care range from nominal amounts in Germany to as much as 20 to 30 percent of regulated fees in France and Japan.

### Insurance Financed by Payroll-Based Contributions From Employer and Employee

Workplace-based insurance in France, Germany, and Japan is largely financed by mandatory payroll contributions from both employees and employers. In contrast to private insurance financing in the United States, which generally reflects each individual group's expected costs of care, these mandatory contributions reflect the average cost of a larger cross section of the population than typically used by U.S. insurers in calculating premiums. (In France and Japan, payroll-based financing is supplemented by subsidies from general tax revenues.)

### Countries Set National Limits on Spending and Require Uniform Payment Rates

Each country has national procedures for setting limits on health care spending and for determining standardized reimbursement rates for providers. Generally, a government agency or other authorized body sets broad targets for all or some components of health care spending. The targets may serve as guidelines or they may be binding. National laws also require that payers reimburse providers according to rates that are, for the most part, uniform; a given service is usually reimbursed at the same rate, regardless of payer.

Each country also has a formal process for setting payment rates for physicians and hospitals. The health care system's major stakeholders—third-party payers, physicians and hospitals, and (in France and Japan) the government—participate in this rate-setting process. In France and Germany, the rates are set in formal negotiations. In Japan, they are set by the government in consultation with a body that represents insurers and health care providers.

### Countries Adopt Direct Controls on Prices and Overall Spending

Seeking to moderate the rise in health care spending, all three countries have imposed direct controls on health care prices and overall spending. These controls are comprehensive—applying to the entire health care industry or to a major health care sector. By use of standardized payments, mandated coverage, and mandated benefits, the three countries have alleviated a potential problem with direct controls, known as cost shifting (that is, providers offset both the cost of charity care and the lower reimbursement from some patients' insurers by raising charges to other, more generous insurers).

## Budget Controls With Teeth Work Better Than Price Controls at Containing Spending

France and Germany implemented budget controls that were subject to different degrees of enforcement— Germany, starting in the late 1970s; France in the mid-1980s. These controls supplemented or replaced price controls that were already in place. Both countries set annual targets to limit total spending on hospital services, and Germany set targets and, later, caps to limit total spending on outpatient physician services. GAO's econometric analyses confirm that stringent enforcement makes budget controls more effective.

### Hospital Spending in France and Germany

Spending limits restrained hospital spending in France but not in Germany. Beginning in 1984, the French government replaced its fixed daily rates for hospital care with targets for total public hospital spending. To enhance compliance with the targets, the government participates in budget negotiations with each individual public hospital. GAO estimates that between 1984 and 1987, the targets reduced French spending on hospitals by about 9 percent below what would have been spent had price controls remained in place. By contrast, Germany in 1985 established targets for total hospital spending, but did not design the means to enforce them. GAO found no statistical evidence that the existence of targets affected German spending for total hospital services between 1985 and 1987.

### Physician Care Spending in Germany

Stringent enforcement enhanced the effectiveness of Germany's budget controls on physician spending. In 1978, Germany complemented its existing price controls with spending targets (though not with a formal enforcement mechanism). In 1986, however, Germany replaced targets with caps that were binding. GAO estimates that between 1977 and 1987, Germany's use of budget controls reduced inflation-adjusted spending by as much as 17 percent below what would have been spent on physician care under price controls alone. In addition, GAO found that caps reduced the rate of spending growth more than targets. Spending growth in the physician sector averaged 2 percent annually under caps, compared with 7 percent annually under targets; caps account for part, but not all, of this difference.

## Countries Seek Additional Policies to Better Restrain Spending, Assure Quality, and Enhance Efficiency

In the countries reviewed, budget controls that successfully tempered the pace of spending growth have not relieved all pressures on spending nor have they attempted to address concerns about the quality and efficiency of health care. Increased spending can be attributed, in part, to sectors not controlled through budgets, such as physician services in France or prescription drugs in all three countries. Continued pressure to increase health care spending in the future is also expected, as the elderly's share of the population rises further and new, expensive medical treatments are introduced.

In addition, the continued tightening of budget controls may, over time, both create political pressures for a relaxation of the controls and make a health care system less able to provide high-quality services. In France, new proposals for stronger budget controls recently sparked widespread protests by physicians. In Germany, some controls on physician spending were relaxed in mid-1991 due to pressure applied by physicians. With respect to quality, GAO found no evidence in the countries reviewed of a decline in broad measures of health status during the relatively brief period that budget controls were in effect. Experts in France, however, believe that tight hospital budgets there are discouraging hospital maintenance and the development of innovative procedures. In other countries that have used budget controls for longer periods than France and Germany, some shortages of services have appeared, indicating the potential for problems in the long run.

Health care experts in these three countries are exploring policies that enhance efficient delivery and better assure quality. For example, efforts are being made in France and Germany to develop a prospective payment system for hospitals—following the same general principles used in the U.S. Medicare program since 1983—that offers incentives for more efficient delivery of hospital care. Germany is developing programs that enhance quality by increasing physician monitoring, formalizing quality assurance procedures, and increasing the coordination of inpatient and outpatient services.

## Recommendations

GAO is not making recommendations in this report.

## Agency Comments

GAO did not solicit agency comments.

# DEBATE PROPOSITION – RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE CATASTROPHIC HEALTH INSURANCE TO ALL UNITED STATES CITIZENS

# Catastrophic Health Insurance: Medicare

## SUMMARY

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. The absence of catastrophic health insurance protection for the elderly was the subject of concern for several years. During the 100th Congress, a number of proposals were considered to expand protection for the aged through the Medicare program. The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360) was signed into law on July 1, 1988. This measure placed an upper limit on beneficiary liability in connection with covered Medicare services. It also established a new catastrophic prescription drug program. The measure did not include protection against long-term institutional care expenditures in the benefit package.

MCCA removed coinsurance and number-of-day limitations on hospital care; a beneficiary needing hospital care would pay only one inpatient deductible per year. The law modified the skilled nursing facility benefit and expanded benefits for home health and hospice care. The law established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for cost-sharing charges in connection with physicians' and other Part B services. Beginning in 1991, the law authorized Medicare coverage for catastrophic outpatient prescription drug expenses. MCCA was to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which was to be mandatory for all Part A enrollees with Federal tax liability (about 41% of the elderly in 1989). MCCA also contained several Medicaid provisions.

Many elderly complained about the supplemental premium; many also questioned the need for the new benefits. Further, concerns were raised regarding the rapid increase in estimated MCCA costs. During 1989, Congress considered ways to modify MCCA. Such modifications included developing a plan retaining a portion of the MCCA benefits, while reducing or eliminating the supplemental premium. However, a consensus could not be reached.

Thus, on Nov. 22, 1989, the House and Senate cleared the Medicare Catastrophic Coverage Repeal Act of 1989 (H.R. 3607), for the President's signature; it was signed into law Dec. 13 (P.L. 101-234). The Act repeals the Medicare catastrophic provisions included in MCCA; however, it retains the Medicaid provisions.

On Nov, 6, 1990, the President signed into law the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990; P.L. 101-508.) This legislation restored two benefits which had been added by MCCA and removed by the repeal law -- coverage of mammography screening services and expansion of hospice benefits. OBRA 1990 also strengthens standards relating to Medicare supplemental health insurance (medigap) policies.

Reprinted from Catastrophic Health Insurance: Medicare; Issue Brief, by Jennifer O'Sullivan. Washington, Congressional Research Service, 1990. 16 p.

## ISSUE DEFINITION

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. Further, these expenses must be the liability of the individual or family; that is, they are not covered by so-called third parties, either private insurance or public programs. Congress passed the Medicare Catastrophic Coverage Act of 1988 (MCCA), which provided protection against some catastrophic costs for the elderly. After enactment, a number of issues were raised about MCCA. Of particular concern was the financing mechanism. Critics also focused on the increases in MCCA estimated costs. On Nov. 22, 1989, the House and Senate cleared the Medicare Catastrophic Coverage Repeal Act of 1989 (H.R. 3607) for the President's signature; the measure was signed into law (P.L. 101-234) on Dec. 13, 1989.

## BACKGROUND AND ANALYSIS

### Insurance Coverage for the Aged

#### Medicare Coverage

Aged persons who face catastrophic health expenses do so because of gaps in their insurance coverage. Almost the entire aged population (between 95 and 96% or 30 million persons) are covered under Medicare; in addition,the program covers 3 million disabled persons. Medicare's benefits, which are the same throughout the country, are targeted toward meeting the acute health care needs of the elderly. Prior to 1989, limits were placed on the number of covered days of hospital care and continue to be placed on skilled nursing facility care. (The hospital limits will be restored in 1990.) Further, the program has placed no upper limit on cost sharing charges in connection with covered program services.

Overall, Medicare covers about half of the aged's health care costs. The program's benefit package excludes prescription drugs, routine eye examinations, eyeglasses, hearing aids, dental care, dentures, and most preventive care. The major gap in the Medicare benefit package is coverage of long-term-care services. Nursing home coverage is limited to short-term post-hospital stays in skilled nursing facilities (SNFs). As a result, Medicare covers less than 2% of the nursing home costs of the aged. Home health care is covered only when a beneficiary can be shown to need intermittent skilled nursing care or physical or speech therapy. Many chronically ill persons do not need skilled care to remain in their homes, but rather, need custodial care and assistance with daily routines; home health services for these persons are not covered by Medicare.

#### Other Insurance Protection

The majority of Medicare beneficiaries have had some insurance protection in addition to Medicare coverage. The largest group is that with **Medigap coverage**. Medigap is the term used to describe individually purchased policies designed to supplement Medicare's coverage. Approximately 39% of the noninstitutionalized Medicare population purchased private health insurance policies in 1987, most of which could be classified as Medigap. The principal protection offered by the majority of these policies is coverage of Medicare's cost sharing charges; some policies may offer coverage of additional services. Few policies offer protection against the costs of long-term institutional care -- potentially the most costly service item.

Regulation of insurance, including health insurance, is generally a State responsibility. However, in the 1970s there were a series of reports on marketing and sales abuses with respect to health policies sold to the elderly. Congress therefore approved a voluntary certification program in 1980. Under the program, policies that wished to be certified as Medigap policies had to meet or exceed standards set forth in a model regulation approved by the National Association of Insurance Commissioners (NAIC). The voluntary program applied only in States that failed to establish equivalent or more stringent programs. Almost all States established their own programs. (See MCCA summary; summary of MCCA repeal, and OBRA 1990 for Medigap provisions.)

Approximately 29% of the noninstitutionalized Medicare population has **employer-based health insurance coverage** which may be paid in whole or part by their employers. Employer-sponsored plans are not covered by the NAIC rules. (See MCCA summary and summary of MCCA repeal for maintenance of effort provision.)

Some low-income aged and disabled Medicare beneficiaries are also covered by the Federal-State **Medicaid** program. However, many of the aged do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standard through their expenditures on health care. Medicaid beneficiaries are effectively protected against the costs associated with covered program services.

Prior to MCCA, an estimated 20% of the Medicare population had no other health insurance coverage. According to DHHS, this figure included over 2 million poor and 6 million near-poor elderly not covered by Medicaid.

## Enactment of MCCA

President Reagan submitted the Administration proposal for catastrophic coverage for the Medicare population on Feb. 24, 1987. It was seen by many in Congress as defining the minimum parameters of a Medicare expansion bill. The final law differed considerably from the original Administration plan. The major benefit expansion included in the law was the new catastrophic prescription drug coverage.

Financing was a key issue during Congressional consideration of MCCA. Given the Federal budget deficit, it was decided that any program expansions could not rely on general revenue financing. Therefore another mechanism had to be developed. It was determined that, first, the legislation must provide the revenues for any benefit expansions. Second, expanded benefits had to be paid for by the beneficiaries themselves. As the legislation was developed, there was concern that many beneficiaries would be unable to afford the cost of the improved benefits, if the cost were to be spread equally across all beneficiaries. The law therefore provided that those with a greater ability to pay (as evidenced by Federal tax liability) would shoulder a larger portion of the costs. On the other hand, State Medicaid programs would be required to phase in coverage of Part B premium payments (and other Medicare cost-sharing charges) for those with incomes below the poverty line.

## Summary of MCCA

The Medicare Catastrophic Coverage Act of 1988 was given final approval by Congress June 8, 1988, and signed into law as P.L. 100-360 July 1, 1988. The following are highlights of the major provisions. (For a detailed summary see CRS Report 89-155 EPW, Medicare Catastrophic Coverage Act of 1988.) The hospital and SNF benefit expansions were effective Jan. 1, 1989; the remaining benefit provisions (except drugs) were to be effective Jan. 1, 1990. The catastrophic prescription drug benefit was to be effective Jan. 1, 1991.

### Part A (Hospital Insurance) Benefits

Part A provides coverage for inpatient hospital services, skilled nursing facility (SNF) services, home health care, and hospice services. Prior to the enactment of MCCA, long-term hospital stays were subject to significant coinsurance charges. Further a beneficiary could potentially exhaust all benefits; however, a very small percentage actually did so. MCCA made the following Part A changes:

**Inpatient Hospital Services.** Specified a maximum of one hospital deductible per year ($560 in 1989) and eliminated the day limits, coinsurance charges, and spell of illness provisions.

**Skilled Nursing Facility Services.** Required daily coinsurance payments for the first 8 days equal to 20% of the national average Medicare reasonable cost for SNF care ($25.50/day in 1989); eliminated coinsurance charges for 21st-100th days; provided coverage for up to 150 days and eliminated prior hospitalization requirement.

**Home Health Services.** Expanded the "intermittent" skilled nursing care definition so that "daily" care was defined as 7 days a week for up to 38 days (instead of 5 days a week for up to 2 or 3 weeks).

**Hospice Services.** Provided that the 210 day lifetime limit could be extended.

### Part B (Supplementary Medical Insurance) Benefits

Beneficiaries enrolled in Part B pay a monthly premium ($31.90 a month in 1989). They are also liable for certain charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and 20% coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's determination of the "reasonable charge" amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. (This is sometimes referred to as the "balance billed" amount.) The following are the Part B changes which were made by MCCA.

**Limitation on Out-of-Pocket Expenses.** Established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for Part B cost-sharing charges after which Medicare would pay 100% of the approved amount. (Balance billing charges would not count toward the cap; nor would Medicare pay these charges once the beneficiary hit the cap.) The limit was set at $1,370 for 1990; it was to be indexed so that a constant 7% of beneficiaries would be eligible for this catastrophic benefit each year.

**Mammography Screening.** Established a new Medicare benefit. Screenings for women over 65 would be covered every other year, subject to a maximum payment per screening of $50 in 1990 (indexed in future years).

**Respite Care.** Provided coverage for in-home care for a chronically dependent individual for up to 80 hours per year. The benefit was to be available only for persons who met either the catastrophic cap or the outpatient prescription drug cap.

### Catastrophic Prescription Drug Benefits

MCCA established, effective Jan. 1, 1990, a limited prescription drug benefit for home intravenous (IV) drugs and immunosuppressive drugs furnished after the first year following a transplant (they are already covered in the first year). The deductible was to be $550 in 1990; the coinsurance was to be 20% for home IV drugs and 50% for immunosuppressives. Beginning Jan. 1, 1991, catastrophic prescription drug coverage was to be available for all outpatient prescription drugs, subject to a $600 deductible and 50% coinsurance charges. The deductible was slated to go to $652 in 1992 and be indexed in future years so that 16.8% of beneficiaries would reach the deductible each year. The coinsurance was slated to be lowered to 40% in 1992 and 20% in 1993.

### Financing

The new benefits were to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which was to be mandatory for all those entitled to Part A who had Federal tax liability of $150 or more.

**Part B Premium.** The additional monthly Part B premium was set in the statute through 1993. The additional monthly amount was set at $4 in 1989, $4.90 in 1990, $7.40 in 1991, $9.20 in 1992, and $10.20 in 1993.

**Supplemental Premium.** The supplemental premium (to be collected in conjunction with the Federal income tax) was to be based on Federal tax liability (i.e., amount of taxes owed). The supplemental premium was in effect a surtax. The surtax rate was to be 15% in 1989, 25% in 1990, 26% in 1991, 27% in 1992, and 28% in 1993. The maximum annual premium per enrollee was $800 in 1989, rising to

$1,050 in 1993. It was estimated that the approximate income levels at which the maximum premium amounts would be reached were $40,000 for a single return and $80,000 for a couple.

### Other Provisions

**Medigap Policies.** MCCA amended procedures for Federal certification of Medigap policies. It provided that if the National Association of Insurance Commissioners (NAIC) revised its standards prior to Oct. 1, 1988, such revised standards would apply as the standard for certification. The NAIC met this deadline. Policies sold before enactment, but still in effect on Jan. 1, 1989, were deemed not to duplicate Medicare's new benefits if they complied with the NAIC model transition rule; this rule required insurers to notify beneficiaries of policy and premium changes and to make appropriate premium adjustments in their policies.

**Maintenance of Effort.** Any employer who provides health benefits to an employee or retired former employee (including State and local employees) that duplicate at least 50% of the new or improved Part A or Part B benefits would have to provide additional benefits or refunds that totalled at least the actuarial value of the duplicative benefits. The provision was to be effective with respect to Part A benefits in 1989 and Part B benefits in 1990 except that an extension was provided to cover current collective bargaining agreements.

**Federal Employees.** MCCA required the Director of the Office of Personnel Management (OPM) to reduce, effective Jan. 1, 1989, the rates charged to Medicare-eligible individuals participating in the Federal Employee Health Benefits Program (FEHBP) to reflect the amounts that would have been paid by those plans except for the enactment of this bill. The reduction was $3.10 per month in 1989. OPM was also required to conduct a study of changes to FEHBP that might required to incorporate plans designed specifically for Medicare-eligible individuals.

**Medicaid.** MCCA mandated States, on a phased-in basis, to pay Medicare premiums, deductibles and coinsurance for elderly and disabled individuals with incomes below the poverty line. Also, in the case of a couple where one member is institutionalized, the bill provided protection of a portion of the couple's income and resources for maintenance needs of the community spouse (the so-called spousal impoverishment provision).

## Estimated Impact of MCCA

All beneficiaries had increased insurance protection as a result of the new law. The Congressional Budget Office (CBO) estimated that when the legislation was fully implemented, approximately 22% of Medicare beneficiaries each year would have been entitled to higher benefit payments as a result of the program expansions.

At the time of enactment, total new benefit and administrative costs were estimated at $30.8 billion over the FY1989-93 period. This figure increased to $48.2 billion in September 1989. These costs were to be financed through the additional Part B premium and the new supplemental premium. It was estimated that 41.2%

of enrollees would pay the supplemental premium in 1989. Close to two-thirds of those paying the premium would pay less than $300. An estimated 5.6% of enrollees would pay the maximum supplemental premium in 1989.

It was estimated that approximately 30% of enrollees would pay more in new premiums (supplemental plus the new Part B) than they would receive in new benefits. However, all persons (including those paying the maximum supplemental premium) would still receive more in total Medicare benefits than they would pay in total. This was true even when you included the hospital insurance payroll tax which was paid by these individuals (and their employers) during their working years.

## MCCA Issues

Following passage of MCCA, a number of issues were raised about the scope of the new legislation and its financing. Critics of the measure focused mainly on the financing aspects. Some persons who would be liable for the new supplemental premium (also known as the surtax) objected to the amount they would have been required to pay for the expanded coverage. Most persons liable for the supplemental premium would have averaged more in total new premium charges (supplemental plus Part B) than the per capita value of the new benefits. Critics further objected to the mandatory nature of the program; they felt that beneficiaries should be allowed to make their own choices about insurance coverage.

Proponents of the measure noted that, given the Federal budget deficit, it was decided that any program expansions could not rely on general revenue financing. Therefore another mechanism had been chosen. All beneficiaries, except those with incomes below the poverty line, would pay a portion of the additional costs. Higher-income individuals would assume a higher percentage of the costs. Proponents note that even though higher-income individuals would be paying more than the value of the new benefits, they would still be receiving a subsidy on the overall Medicare benefits package. Further, financing Medicare through an income-related charge was not new to Medicare. The Part A program has always been financed by an income-related hospital insurance tax levied on current workers and their employers.

Proponents noted that the program was mandatory rather than voluntary to help maintain a sound financial base. The mandatory base was intended to prevent those beneficiaries who were younger, healthier, and had higher incomes from dropping out of the program until they were older, sicker and more likely to need the protection.

Critics noted that over three-quarters of Medicare beneficiaries already had private and or public health insurance coverage in addition to Medicare. They suggested that these individuals did not need, nor in many cases want, expanded Medicare coverage. Some individuals who had their additional coverage paid for in whole or in part by their current or former employer would have been subject to the supplemental premium and therefore have been subject to higher total charges after enactment of MCCA.

Proponents of the measure stated that it represented the most significant expansion in benefits since the enactment of Medicare in 1965. They noted that the law was designed to fill very significant program gaps. While many enrollees had other health insurance protection, approximately 20% of the aged had no additional coverage. These individuals tended to be older, sicker and poorer than those who purchased additional coverage.

Proponents noted that Medicare is more efficient to administer than private insurance. They also noted that it may be difficult for those elderly with preexisting conditions to obtain affordable private coverage.

Some persons suggested that persons will be paying for coverage that they will not actually use. Proponents noted that the new legislation provided catastrophic insurance protection. As with car insurance or homeowners insurance, not everyone expects to avail themselves of the benefits each year. However, if the program had been fully implemented, an estimated 22% of beneficiaries would have been entitled to higher Medicare payments as a result of the legislation.

Some critics of the catastrophic measure questioned its focus. They suggested that enactment of the catastrophic proposal would, in effect, delay enactment of a long-term-care bill. They noted that the major gap in Medicare was and continued to be coverage of long-term-care services. Very few private insurers offer protection against these costs. As a result, Medicaid remains the primary source of third party financing for these expenses. Many elderly at risk of needing long-term-care services face the prospect of impoverishing themselves to welfare levels in order to gain Medicaid eligibility.

## Congressional Action in the 101st Congress

During the 1st Session of the 101st Congress, both the House and Senate considered a number of alternative approaches to modifying MCCA. This interest was spurred in large part by the considerable opposition that was voiced by many senior citizens to imposition of the supplemental premium. It was also spurred in part by the considerable increase in estimated program costs of catastrophic benefits. Two services accounted for most of the estimated increase -- the expanded skilled nursing facility benefit and the prescription drug benefit.

On Oct. 4, 1989, the House during its consideration of the FY1990 budget reconciliation bill approved the amendment offered by Congressmen Donnelly and Archer by a vote of 360 to 66. This replaced the catastrophic provision approved earlier by the Committee on Ways and Means. The House rejected the substitute amendment offered by Congressmen Stark, Gradison, and Waxman. The Donnelly/Archer amendment basically repealed the Medicare provisions and the financing provisions of MCCA while retaining the Medicaid provisions.

On Oct. 6, 1989, the Senate by a vote of 99 - 0 approved S. 1726, as amended. This legislation was introduced by Senator McCain as a free-standing measure. (Earlier efforts by the Finance Committee to report a catastrophic agreement as part of reconciliation were unsuccessful.) The Senate's action came after a series of amendments (including a repeal amendment) were disapproved. The Senate bill retained the Part A benefit with the exception of the SNF benefit. It also retained coverage for immunosuppressives and home IV drugs, mammography services, and respite care. The Senate bill eliminated the supplemental premium and provided beginning in 1990 for a recalculation of the Part B premium to fund the remaining benefits.

On Nov. 8, 1989, the House passed H.R. 3607, the Medicare Catastrophic Coverage Act of 1989. The provisions of this bill were identical to the catastrophic provisions approved by the House as part of the reconciliation bill. Also on Nov. 8, 1989, the Senate passed its version of H.R. 3607. The Senate version was a revised McCain bill which corrected technical errors incorporated in S. 1726. The Conferees reported the measure on Nov. 19, 1989. The Conferees essentially reported the House repeal measure with a few modifications. The Senate rejected the measure twice returning the measure to the House; the latter body insisted on the conference agreement. Both Houses approved the conference report with technical correction on Nov. 22, 1989. The bill was signed into law (P.L. 101-234) on Dec. 13, 1989.

## MCCA Repeal Provisions

The following summarizes the provisions of H.R. 3607 as approved by Congress.

### Part A Provisions

**Hospital and SNF Benefits.** The expanded hospital and SNF benefits authorized by MCCA were effective Jan. 1, 1989. P.L. 101-234 restores the prior law provisions effective Jan. 1, 1990.

Beginning Jan. 1, 1990, hospital and SNF benefits will again be tied to the beneficiary's "spell of illness." A spell of illness begins when a beneficiary enters a hospital and ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days.

A beneficiary is entitled to 90 days of hospital care per spell of illness." Days 1-60 are subject to one deductible ($592 in 1990). Days 61-90 are subject to a daily coinsurance charge ($148 in 1990). Beneficiaries also have a total of 60 lifetime reserve days available to them. A beneficiary exceeding 90 days of care during a spell of illness may use lifetime reserve days, subject to a daily coinsurance charge ($296 in 1990). Lifetime reserve days can be used only once; any such days used by a beneficiary prior to 1989 are subtracted from the total available.

A beneficiary is also entitled to 100 days of SNF care per spell of illness. The three-day prior hospitalization requirement removed by MCCA has been restored. Days 1-20 of post-hospital SNF care are not subject to beneficiary cost-sharing. Days 21-100 are subject to daily coinsurance charges ($74 in 1990).

P.L. 101-234 establishes transition provisions for persons in a hospital on Jan. 1, 1990 whose inpatient stay began prior to that date. For these individuals, January 1, 1990 is considered to be the first day of the beneficiary's spell of illness; however, no deductible is imposed if one was imposed for such stay in 1989. Also, if a deductible was imposed on an inpatient stay beginning in December 1989, no deductible is to be imposed for a spell of illness beginning in January 1990. Further, no deductible is imposed on an individual whose spell of illness began prior to Jan. 1, 1990.

P.L. 101-234 also establishes transition provisions for persons in a SNF on Jan. 1, 1990 whose SNF care began prior to that date. The 100 days of SNF care are deemed to start on Jan. 1, 1990. Thus, no coinsurance would be imposed on days 1-20; the daily $74 coinsurance charge would be imposed on days 21-100. Persons in the SNF prior to Jan. 1, 1990 would not be subject to the prior hospitalization requirement. The prior hospitalization requirement is also waived for persons discharged from a SNF during Dec. 1989 and readmitted in Jan. 1990 within 30 days of discharge.

**Home Health Benefits**. The expanded home health benefits (see MCCA summary) which were to become effective Jan. 1, 1990 are repealed.

**Hospice Benefits**. The 210 limitation is restored Jan. 1, 1990, except that it does not apply to persons electing hospice benefits prior to that date.

**Blood Deductible**. P.L. 101-234 retains the MCCA provision. MCCA provided that the Part A blood deductible is to be imposed on a calendar year basis; it is to be reduced by any such deductible imposed under Part B.

**Part A Premium**. The vast majority of the elderly are automatically eligible for Part A protection. Persons not automatically eligible may obtain coverage through payment of a monthly premium ($156 in 1989.) MCCA revised the calculation of that premium. P.L. 101-234 retains this modification.

**PPS Payments**. MCCA provided for transitional adjustments in PPS payments to take into account the new law. Further, for PPS-exempt hospitals, it provided for an adjustment in the target amount (the annual limit on total Medicare payments to such hospital) to take into account the additional days of care Medicare would be covering.

P.L. 101-234 terminates the transitional adjustments for PPS and PPS-exempt hospitals effective Jan. 1, 1990. Further, it requires the Secretary to make appropriate adjustments in the target amount to take into account services provided to an inpatient whose stay began before Jan. 1, 1990.

### Part B Provisions

The following new Part B benefits which were to become effective Jan. 1, 1990 are **repealed**:

-- Limitation on out-of-pocket expenses (the so-called Part B cap)
-- Screening mammograms
-- Respite care
-- Home intravenous drug therapy services

### Catastrophic Prescription Drugs

Coverage for outpatient catastrophic prescription drugs, which was to begin on a limited basis in 1990, is repealed.

MCCA required that physicians include the appropriate diagnosis code when requesting Medicare payment, effective Mar. 1, 1989. This requirement is retained.

### Financing

MCCA provided that the supplemental premium was to be effective for tax years beginning after Dec. 31, 1988. P.L. 101-234 repeals this premium. While most persons would not have paid the premium until they filed their 1989 tax returns, some persons may have paid a portion of this as part of their estimated tax payments. A separate refund of this amount will not be made. Repeal of the premium results in reduced tax liability. If an individual's total 1989 tax payments exceed total 1989 tax liability, a refund will be made when the individual files his or her return.

MCCA also increased the monthly Part B premium by a specified amount to fund catastrophic expenses. This add-on amount was set at $4 per month in 1989 and $4.90 per month in 1990. The additional premium is deducted from individual's social security checks (as is the case for the basic Part B premium amount). The additional premium is repealed effective January 1990. Due to the late passage of the repeal legislation, the 1990 add-on amount will be deducted for several months until the system can be appropriately modified. Any resulting overpayment will be refunded.

MCCA extended indefinitely the hold harmless provision. This provision prohibits a beneficiary's check from dropping as a result of an increase in the Part B premium. This indefinite extension is retained.

MCCA also established several new trust funds and accounts. P.L. 101-234 repeals the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, the Federal Catastrophic Drug Insurance Trust Fund, and the Medicare Catastrophic Coverage Account.

MCCA required the Secretary of the Treasury to study and report to Congress by Nov. 30, 1988 on Federal tax policies to promote the private financing of long-term care. P.L. 101-234 delays the reporting date until May 31, 1990.

### Medigap Provisions

**Revised Certification Requirements.** MCCA amended procedures for Federal certification of Medigap policies to reflect enactment of catastrophic coverage. (See above.) P.L. 101-234 amends the requirements to reflect repeal of catastrophic coverage. P.L. 101-234 provides a period of 90 days beginning with enactment for the NAIC to revise their model medigap regulation to improve such regulation and otherwise to reflect benefit changes made by the new law. The revised regulation would apply in a State effective on the date the State adopts Medigap standards equal to or more stringent than the revised regulation or one year after the date the

NAIC first adopts such revised regulation. If the NAIC does not revise the model regulation within 90 days, the Secretary must promulgate revised Federal model standards within the subsequent 60 day period. These standards would become effective on the earlier of the date the State adopts the standards equal to or more stringent than the revised standards or one year after the date the Secretary promulgates the standards. After the date the revised regulation (or the revised Federal model standards) are effective in a State, no Medigap policy may be certified by the Secretary and no Secretarial certification may remain in effect unless the policy meets the revised NAIC model standards (or the revised Federal model standards.)

P.L. 101-234 defines a transition deadline as one year after the NAIC adopts the revised model regulation, or one year after the Secretary promulgates revised Federal model standards, as the case may be. Medigap policies issued after the transition deadline must comply with the revised NAIC model regulation or the Federal model standards to be in compliance. Medigap policies issued before the transition deadline are deemed to be in compliance with the new standards if they comply with a transition provision to be issued by the NAIC no later than Dec. 15, 1989 (or failing that, by the Secretary by Jan. 1, 1990.) The NAIC transition provision ceases to apply on the earlier of either the date the State adopts standards equal to or more stringent than the revised NAIC model regulation (or the revised Federal model standards, if appropriate) or the date established for States requiring legislative action.

Medigap policies in effect on Jan. 1, 1990 would not meet the standards unless each policy holder or certificate holder who is eligible for Medicare is sent a notice by Jan. 31, 1990 explaining the changes in Medicare's benefits resulting from catastrophic repeal legislation and how these changes affect the policy's benefits and premium.

**Continuation Provision**. Special rules are established in the case of an individual who had a Medigap supplemental policy in effect as of Dec. 31, 1988 with an insurer (as a policy holder, or in the case of a group policy, a certificate holder) and terminated this policy before enactment of P.L. 101-234. The insurer must offer such policy holder or certificate holder (through written notice between Dec. 15, 1989 and Jan. 30, 1990) reinstitution coverage. The individual must be offered during a period of at least 60 days (beginning not later than Feb. 1, 1990) reinstitution coverage, with coverage effective as of Jan. 1, 1990. The offering must be under the terms which: (1) do not provide for any waiting period for treatment of pre-existing conditions; (2) provide for coverage which is substantially equivalent to coverage in effect before the date of such termination; and (3) provide for classification of premiums on terms which are at least as favorable to the policyholder or certificate holder as the premium classification which would have applied to that person had the coverage not been terminated. An insurer is not required to make this offer in the case of a policyholder or certificate holder in another Medigap policy as of the date of enactment of P.L. 101-234 if under that policy, as of Jan. 1, 1990, the individual is not subject to a waiting period with respect to a pre-existing condition.

**Medigap Premiums**. In November 1989, the GAO conducted a survey of commercial Medigap insurers to determine the expected increase in Medigap premiums in 1990. For the 20 companies reporting, the average monthly premium was $58.71 in 1989. In the absence of repeal legislation, the estimated average 1990 monthly premium would be $60.10 in 1990. Repeal of MCCA would result in a 15.4 percent or $9.25 average increase in the 1990 monthly premiums. This represented increases ranging from 6.3% to 41.3% across reporting companies.

The Blue Cross and Blue Shield Association estimated the impact of repeal on member plans. A typical nongroup Medicare product costs an estimated $50 to $55 per month in 1989. Repeal of MCCA would result in increases of $8 to $24 per month in 1990.

### Other Provisions

P.L. 101-234 **repeals** the following additional MCCA provisions, effective Jan. 1, 1990:

- Maintenance of effort. The repeal does not apply to duplicative Part A benefits for periods before Jan. 1, 1990. (See summary of MCCA above.)
- Rate reduction for Federal annuitants.
- OPM study of offering Medigap policies to Federal annuitants (This study has already been issued.)
- Benefits counseling and assistance demonstration project.
- Case management demonstration projects.
- Advisory Committee on Medicare home health claims.
- Research on long-term-care services for Medicare beneficiaries.
- Study of adult day health services.

The following provisions were **retained**:

- United States Bipartisan Commission on Comprehensive Health Care (the Pepper Commission).
- Mailing of notice of Medicare benefits and information describing the participating physician program.
- Prohibition of misuse of symbols, names, or emblems in reference to Social Security or Medicare.
- Demonstration projects for chronic ventilator dependent units in hospitals.
- HMO provisions relating to adjustment of contracts and changes in civil monetary penalties with respect to certain actions.
- Technical corrections to OBRA 1987.

P.L. 101-234 also requires prepaid health plans, for calendar year 1990 only, to provide the additional Part A and Part B benefits otherwise repealed. The adjustments in the 1990 premium rates are retained to cover the costs of these benefits.

### Medicaid

P.L. 101-234 **retained** the Medicaid provisions of MCCA. These provisions are as follows:

- Requiring Medicaid to pay Medicare premiums and cost-sharing charges for Medicare beneficiaries below poverty.
- Spousal impoverishment provision which, in the case of the institutionalization of one member of a couple, provides protection for a

portion of the couple's income and resources for the maintenance needs of the community spouse.

- Requiring Medicaid coverage of pregnant women and infants below poverty.

In November 1989, GAO conducted a survey of the impact of repeal of MCCA's Medicare provisions on Medicaid budgets. The 37 States (and the District of Columbia) reporting data showed a total increase in 1990 budgets of $1 billion, of which an estimated $444 million would be State funds and $587 Federal funds.

## OBRA 1990

During the second session of the 101st Congress, several measures were introduced to restore selected benefits which had been added by MCCA and subsequently repealed. Generally the benefits proposed for restoration were some of the less costly. OBRA 1990 restores two benefits which were added by MCCA and removed under the repeal bill. Specifically, it provides coverage for biennial mammography screenings and provides that the 210 lifetime limit for hospice services may be extended. The law also accelerates implementation of a MCCA Medicaid provision by requiring States to cover, by Jan. 1, 1991, all Medicare cost-sharing charges for Medicare beneficiaries with incomes below poverty and assets below twice the figure applicable under the Supplemental Security Income (SSI) program. It also adds a new provision requiring all States, beginning Jan. 1, 1993, to cover Part B premium charges only for Medicare beneficiaries with incomes below 110% of poverty and assets below twice the SSI level.

The second session of the 101st Congress also examined issues related to Medigap insurance. OBRA 1990 makes a number of modifications to the Medigap requirements including the following:

- **Simplification of Policies**. Benefit options are to be simplified to provide for a core group of benefits, and up to a maximum of nine other groups of defined Medigap packages. The core group is to be common to all Medigap benefit packages and must be offered by all Medigap insurers. The simplification standards may be waived in any state that has an alternative simplification program in effect on the date of enactment.

- **Uniform Policy Description.** To facilitate comparisons among policies, sellers of policies will be required to provide, before the sale of a policy, an outline of coverage which describes the policy's benefits using a standard form. In addition, policy benefits are to be described using uniform language, definitions, and format.

- **Prevention of Duplicate Medigap Coverage**. Sellers of policies will be required to obtain from the applicant a statement of what kind of insurance the applicant has, the source of health insurance, and whether he or she is entitled to Medicaid. It will be unlawful to sell or issue a duplicate policy unless the applicant indicates that the policy replaces an existing one which will be terminated.

- **Renewability**. Medigap policies must be guaranteed renewable. An issuer may cancel or nonrenew a policy only in the case of nonpayment of premiums or material misrepresentation.

- **Medical Underwriting Limitations.** Medigap insurers will be required to offer coverage to individuals, regardless of medical history, for a six-month period after the individual is first enrolled in Part B. Insurers are to be prohibited from discriminating in price for these policies based on the individual's medical or health status.

- **Enforcement of Standards.** No policy may be sold or issued unless the policy is sold or issued in a State with an approved regulatory program or is certified by the Secretary.

- **Promulgation of Standards.** If the NAIC promulgates standards to implement the OBRA 1990 changes within 9 months of enactment, such standards will be applied in each State for policies to be approved. The standards will apply in the State no later than one year after promulgation by the NAIC.

## LEGISLATION

### P.L. 101-234, H.R. 3607

Medicare Catastrophic Coverage Repeal Act of 1989. Includes provisions repealing the Medicare provisions and the financing provisions of MCCA while retaining the Medicaid provisions. Retains the modified calculation of the Part A blood deductible and the requirement for the U.S. Bipartisan Commission on Health Care (known as the Pepper Commission). Repeals the Part A provisions (which have already gone into effect) at the end of 1989 and establishes transition requirements for persons who were in hospitals or SNFs during 1989. Revises Medigap requirements (including appropriate transition provisions) and includes a continuation provision. Introduced Nov. 7, 1989; passed House Nov. 8, 1989. (Provisions identical to catastrophic coverage repeal provisions included in House-passed H.R. 3299, the Omnibus Budget Reconciliation Act of 1989) Passed Senate amended Nov. 8, 1989. (Contained provisions of Senate-passed S.1726, with technical amendments.) Conference report filed Nov. 19, 1989. Signed into law Dec. 13, 1989.

### P.L.101-508, H.R.5835

Omnibus Budget Reconciliation Act of 1990. Adds Medicare coverage for screening mammography services. Provides that the 210 day lifetime limit for hospice care may be extended. Strengthens Medigap insurance standards. Reported Oct. 15, 1990 by the Committee on the Budget. Passed House Oct. 16, 1990. S.3205 (Sasser) reported by the Committee on the Budget Oct. 16, 1990; passed Senate Oct. 18, 1990. Reported by conferees Oct. 27, 1990. Conference report passed House and Senate Oct. 27, 1990. Signed into law Nov. 5, 1990.

## CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committee of Conference. Medicare Catastrophic Coverage Act of 1988; conference report to accompany H.R. 2470. May 31, 1988. Washington, U.S. Govt. Print. Off., 1988. (100th Congress, 2d session. House. Report no. 100-661)

U.S. Congress. House. Committee of Conference. Medicare Catastrophic Coverage Repeal Act of 1989; conference report to accompany H.R.3607. November 19, 1989. Washington, U.S. Govt. Print. Off., 1989. (101st Congress, 1st session. House Report no. 101-378)

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# Long-Term Care for the Elderly

## SUMMARY

Paying for long-term care services has been an issue before the Congress for a number of years, and the 103rd Congress will likely consider a variety of different proposals for changing the way these services are currently paid for. However, in the context of large Federal budget deficits and increasing spending under existing entitlement programs, it is the issue of cost that provides the central focus of the long-term care debate. Federal and State Governments already are spending large sums on long-term care. In 1991, Federal and State spending for nursing home care -- largely through the Medicaid program -- was in excess of $32 billion; and additional amounts were spent for home care.

Despite these large public expenditures, the elderly face significant uncovered liability for long-term care, and paying for these services, especially nursing home care, can impoverish many of those needing care. The average cost of nursing home care is in excess of $30,000 a year. Most nursing home care is paid for by individuals out-of-pocket or by Medicaid. Medicaid's spending for nursing home care is driven by its coverage of persons who have become poor after depleting their resources and income on the cost of care. Private insurance for long-term care is very limited at present. The result is that the only way people can pay privately for this care is with their own accumulated resources and/or income. At the same time, very little coverage, either through private insurance or public programs, currently exists for the home and community-based services the elderly and their families often prefer over institutional care.

These financing problems are expected to become more acute as a rapidly aging population faces the need for long-term care. An estimated 7.1 million elderly need long-term care services. Of these, an estimated 5.6 million elderly, or almost 80% of the total, live in their own homes or other community-based settings. About 1.5 million elderly reside in nursing homes. Estimates show that the number of elderly needing long-term care may grow from 7.1 million to 13.8 million by 2030, with 5.3 million elderly persons using nursing home care and the remaining 8.5 million residing in the community.

Proposals to expand public financing of long-term care services beyond the coverage provided by a means-tested program like Medicaid can require a large additional commitment of funds. The prospect of large new costs had led to debate about what is the appropriate role for the public and private sectors in financing expanded long-term care coverage. Some believe that the Federal Government should assume the major role in financing additional long-term care services through a new entitlement program. Others believe that the costs of any public sector expansion would be prohibitive and that the private sector through private insurance should take the lead. Still others believe that a combination of public and private sector strategies is needed. Congress has not yet developed a consensus from these divergent viewpoints. Competing demands from other Federal programs, the existence of Medicaid as a safety net program for those needing long-term care, the emergence of a private insurance market for long-term care, and uncertainty about the demand for new benefits have all served to deter major legislative action.

President-elect Clinton has indicated interest in exploring, as part of his health reform proposal, the possibility of including home care options under the Medicare program.

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## BACKGROUND AND ANALYSIS

### Definitions and Need for Long-Term Care

"Long-term care" refers to a broad range of medical, social, personal care, and supportive services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These illnesses and conditions include heart disease, strokes, arthritis, vision and hearing impairments, and Alzheimer's and related dementias.

The need for long-term care is often measured by assessing limitations in a person's capacity to manage certain functions or activities. For example, a chronic condition may result in dependence in certain functions that are basic for self-care, such as bathing, dressing, toileting, getting in or out of a bed or chair, or eating. These are referred to as limitations in "activities of daily living," or ADLs. Assistance with these ADLs may require hands-on assistance or direction, instruction, or supervision from another individual.

Another set of limitations that reflect lower levels of disability are used to describe difficulties in performing household chores and social tasks. These are referred to as limitations in "instrumental activities of daily living," or IADLs, and include such functions as meal preparation, cleaning, grocery shopping, managing money, and taking medicine.

Limitations in ADLs and IADLs can vary in severity and prevalence. Persons can have limitations in any number of ADLs or IADLs, or both. An estimated 7.1 million elderly persons need long-term care because of limitations in ADLs or IADLs. This is nearly one-quarter of the Nation's elderly population. Of the total, 3.3 million elderly persons are estimated to be severely disabled, requiring assistance with at least three ADLs or substantial supervision due to cognitive impairment or other behavioral problems. The remaining 3.8 million are less severely disabled.

Long-term care services are usually differentiated by the settings in which they are provided, with services provided either in nursing homes and other institutions or in home and community-based settings. The great majority of elderly needing long-term care reside in the community. An estimated 5.6 million elderly, or almost 80% of the total 7.1 million elderly needing assistance with ADLs or IADLs, live in their own homes or other community-based settings. Only 1.5 million elderly persons reside in nursing homes.

### Paying for Long-Term Care Services

The way long-term care services are financed will remain of great interest to the 103rd Congress. The table below indicates that the Nation spent $60 billion for nursing home care in 1991. Two sources of payment -- the Medicaid program and out-of-pocket payments -- account for 90% of this total. This pattern of payment reveals that the elderly face significant uncovered liability for long-term care and paying for these services can impoverish many of those needing care.

Medicaid is the Federal-State health program for the poor. It limits coverage to those people who are poor by welfare program standards or to those who have become poor as the result of incurring large medical expenses. Medicaid program data show that spending for the elderly is driven largely by its coverage of people who have become poor as the result of depleting assets and income on the cost of nursing home care. Many elderly people needing long-term care become eligible for Medicaid because of the high cost of nursing home care, currently averaging in excess of $30,000 per year. It is the impoverishing consequences of needing nursing home care that has led policymakers over the years to try to look for alternative ways of financing this care.

**National Nursing Home Expenditures, by Source of Payment, 1991 ($ in billions)**

**Total Nursing Home Care Spending**

| Source of spending | |
|---|---|
| Medicaid | $28.4 |
| Medicare | 2.7 |
| Other Federal | 1.1 |
| Other State and local | .1 |
| Out-of-pocket payments | 25.8 |
| Private insurance | 0.6 |
| Other private | 1.3 |
| Total | 59.9 |

Source: Health Care Financing Administration. Detail does not add to total due to rounding.

The table also indicates that nearly all private spending for nursing home care is paid directly by consumers out-of-pocket. Private insurance coverage for long-term nursing home care is very limited, with private insurance payments amounting to 1% of total spending for nursing home care in 1991. (Private long-term care insurance is discussed in additional detail below.) This pattern of private spending for nursing home care is also a driving force in the long-term care debate. The only way individuals have been able to pay privately for expensive nursing home care is with their own accumulated resources and/or income. There now exists no comprehensive, broadly affordable system for sharing the risk of needing nursing home care.

By far the greatest portion of long-term care spending is for nursing home care. Very little coverage, either through public programs or private insurance, exists for the alternative home and community-based services that the elderly and their families prefer. In 1988 (the last year for which estimates are available), total home care spending amounted to 18 to 24% of total long-term care spending. Spending figures do not take into account the substantial support provided to the elderly by family and friends. Studies have found that more than 70% of the functionally impaired elderly living in the community rely exclusively on unpaid sources, generally family and friends, for their care. Surveys have found that eight out of ten caregivers provide unpaid assistance averaging 4 hours a day, 7 days a week. A large proportion of caregivers are financially disadvantaged and one in three is in relatively poor health. Caregiving frequently competes with the demands of employment and requires caregivers to reduce work hours, take time off without pay, or quit their jobs.

The table also reveals that Medicare plays a very small role in financing long-term care services. Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on coverage of acute health care costs and was never envisioned as providing protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those people who demonstrate a need for daily skilled nursing care following a hospitalization. Many people who require long-term nursing home care do not need daily skilled nursing care, and, therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for less than 4.5% of the Nation's expenditures for nursing home care in 1991.

For similar reasons, Medicare pays for only limited amounts of community-based long-term care services, primarily through the program's home health benefit. To qualify for home health services, the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired people do not need skilled care to remain in their homes, but rather nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel.

Three other Federal programs -- the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) program -- provide support for community-based long-term care services for impaired elderly people. The SSBG provides block grants to States for a variety of home-based services for the elderly, as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the SSI program, the federally administered income assistance program for aged, blind, and disabled people, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible people, including the frail elderly. However, since funding available for these three programs is limited, their ability to address the financing problems in long-term care is also limited. In addition to these Federal programs, a number of States devote significant State funds to home and community-based long-term care services.

Long-term care financing issues are expected to become more pressing in years to come, given current demographic trends and projections of utilization of long-term care services. Estimates show that the number of elderly needing long-term care may grow from 7.1 million to 13.8 million by 2030, with 5.3 million elderly persons using nursing home care in that year and the remaining 8.5 million residing in the community.

## Major Themes of Reform

Concern about long-term care financing is not new. Creation of Federal task forces on long-term care issues, as well as Federal investment in research and demonstration efforts to identify cost-effective "alternatives to institutional care," date back to the late 1960s and early 1970s when payments for nursing home care began consuming a growing proportion of Medicaid expenditures. The awareness that public programs provided only limited support for community-based care, as well as concern about the fragmentation and lack of coordination in Federal support for long-term care, led to the development of a number of legislative proposals beginning in the mid-1970s. Over the years, bills have variously proposed (1) establishing in Medicare new comprehensive long-term care benefits; (2) consolidating certain existing benefits of the Medicare, Medicaid, and SSBG programs into a new program of Federal support for long-term care with uniform benefits and eligibility; and (3) providing block grants to the States for expanded home and community-based care.

While a number of proposals to provide for large scale reform have been considered by Congress over the years, long-term care legislation thus far enacted has taken an incremental approach, principally through limited expansion of existing program support for home and community-based services. Congress has proceeded cautiously in expanding community-based care for a number of reasons. Federal long-term care demonstrations have generally shown that expanded community-based services represent new costs that are not offset by reductions in nursing home spending. In addition, policymakers are concerned about the unpredictability of the demand for community-based care, given the current lack of financing for these services and resulting inadequate information about how people would use services if they were broadly covered under a public program.

Incremental changes enacted into law have included 1981 legislation authorizing the Secretary of the Department of Health and Human Services (DHHS) to allow States to broaden coverage for a range of community-based long-term care services under their Medicaid plans (known as home and community-based waiver programs). In 1982, Congress also established a new Medicare hospice benefit that provides broad home care coverage to terminally ill Medicare beneficiaries. In 1987, Congress gave States limited new authority to provide in-home services for the frail elderly under the Older Americans Act. Most recently, OBRA 90 included provisions that establish in Medicaid a new optional benefit for home and community-based services for the frail elderly, with spending capped at a total of $580 million for five years.

## Current Legislative Issues

In the context of large Federal budget deficits and increasing spending under the Medicare and Medicaid programs, it is the issue of cost, above all, that has provided the central focus of the long-term care debate. Federal and State Governments already are spending large sums on long-term care. In 1991, Federal and State spending for nursing home care -- largely through the Medicaid program -- was in excess of $32 billion; and additional amounts were spent for home care. Proposals to expand public financing of long-term care services beyond the coverage provided by a means-tested program like Medicaid can require a large additional commitment of funds. The prospect of large new costs had led to debate, as yet unresolved, about what is the appropriate role for the public and private sectors in financing expanded long-term care coverage.

### Public and Private Sector Strategies

Policymakers differ in their views about what public and private sector responsibilities should be in financing long-term care. These views have been reflected in a broad spectrum of bills that been introduced in recent Congresses. The 103rd Congress is likely to see similar approaches embodied in legislation introduced this year.

Those advocating a public sector solution argue that all persons at one time or another are at risk of needing long-term care, and this risk can be most efficiently shared by a social insurance program like Medicare that provides coverage to all persons paying a payroll tax during their working years. Public sector advocates also argue that the need for long-term care is no different from the need for medical care; the elderly are not expected to impoverish themselves when they need medical care and should not be expected to do so when they need long-term care.

Private sector advocates, on the other hand, argue that the country cannot afford the tax burden associated with another entitlement program like Medicare. They also argue that, since many elderly persons need long-term care at the end of their lives, a new public entitlement that is not means-tested like Medicaid could have the effect of using scarce public resources to protect assets for younger generations. Those advocating private sector solutions focus on private long-term care insurance as the most promising option for providing greater coverage for nursing home and home care. They propose a variety of tax incentives to individuals and employers for the purchase of this insurance so as to encourage the growth of this relatively new market and to help reduce the high premium costs of policies that most elderly persons cannot now afford.

Still others advocate a partnership between the public sector and private insurance. These persons suggest that the cost of long-term care must be shared by both if a solution is to be found. A broad range of public-private insurance partnerships have been proposed that would establish a larger or smaller role for private insurance, depending on the role that the public sector would play in the particular proposal. Proposals have ranged from partnerships where private insurance would be limited to paying for cost-sharing charges not covered by comprehensive public benefits to others where private insurance would provide the base of coverage and purchase of qualified policies would be subsidized for those persons with low to moderate income.

Congress has not yet developed a consensus from these divergent viewpoints. Competing demands from other Federal programs, the existence of Medicaid as a safety-net program that provides access to long-term care services, an emerging private insurance market, and the prospect of high costs and new taxes to finance new long-term care benefits have all served to deter major legislative action.

## Private Long-Term Care Insurance

Long-term care insurance is a relatively new, but rapidly growing, market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type and an estimated 200,000 people were covered by these policies. By 1987, a DHHS Task Force on Long-Term Care Insurance found 73 companies writing long-term care insurance policies covering 423,000 people. As of December 1991, the Health Insurance Association of America (HIAA) found that more than 2.4 million policies had been sold, with 135 insurers offering coverage.

Although growth has been considerable in a short period of time, the private insurance industry has approached this potential market with caution. Insurers are concerned about the potential for adverse selection for this product, where only those people who are likely to need care actually buy insurance. In addition, they point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, individuals decide to use more services than they otherwise would because they have insurance and/or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of many chronic conditions, people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies are medically underwritten to exclude persons with certain conditions or illnesses. They contain benefit restrictions that limit access to covered care. Policies also limit the period of coverage they offer, typically to a maximum of four or five years. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of covered service. If these amounts are not updated for inflation, the protection offered by the policy can be significantly eroded by the time a person actually needs care. Today policies generally offer some form of inflation adjustment, but only with significant increases in premium costs.

These design features of long-term care insurance raise issues about the quality of coverage offered purchasers of policies. The insurance industry has responded to some of these concerns by offering new products that provide broadened coverage and fewer restrictions. In addition, the National Association of Insurance Commissioners (NAIC) has established standards for regulating long-term care insurance that many States have adopted at least some portion of for regulation of these products in their jurisdictions.

However, policymakers remain concerned about the need for consistent and uniform standards for coverage. The General Accounting Office (GAO) has reported that, while NAIC standards for long-term care insurance have been amended annually and have improved significantly during the past 5 years, States have lagged in adopting the revised standards. GAO also noted that, although NAIC standards provide a foundation for consumer protection, problems remain, including restrictive definitions that limit access to benefits and lack of protection against loss of financial investment in a policy. Bills have been introduced in the 103rd Congress to require long-term care insurance policies to meet certain minimum standards established under State regulatory programs, or in the absence of State action, by the Secretary of HHS. These bills include H.R. 132, H.R. 438, and S. 203.

One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is the affordability of coverage. HIAA has reported on the premium costs of policies providing good coverage in December 1991. These policies paid $80 a day for nursing home care and $40 a day for home health care; they had lifetime 5% compounded inflation protection, a 20-day deductible period, and a four-year maximum coverage period. These policies had an average annual premium in December 1991 of $1,781 when purchased at the age of 65 and $5,627 when purchased at the age of 79. Many elderly people cannot afford these premiums.

The insurance industry believes that affordability of premiums can be greatly enhanced if the pool of those to whom policies are sold is expanded. The industry has argued that the greatest potential for expanding the pool and reducing premiums lies with employer-based group coverage. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing insurance companies to build up reserves to cover future payments of benefits. In addition, group coverage has lower administrative expenses.

According to HIAA, 288 employers offered a long-term care insurance plan to their employees, as of December 1991. These employer-based plans covered over 200,000 employees, their spouses, retirees, parents, and parents-in-law.

But just how broad-based employer interest is in a new long-term care benefit is unclear. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Also, many employers have recently experienced fairly substantial increases in premiums for their current health benefits plans. Very few employers make contributions to the premium cost of a long-term care plan. Almost all employers require that the employee pay the full premium cost of coverage. In contrast, the majority of medium and large size employers pay the full premium cost of regular health care benefits for their employees.

One other suggestion has been offered for increasing the affordability and appeal of long-term care insurance. Various States have been exploring an option for encouraging people to purchase insurance coverage according to the level of assets they wish to protect. Under this approach, States would extend to people buying policies the protection of Medicaid without requiring them to deplete assets as they are required to do now. Instead, people would be able to protect assets according to the amount of long-term care insurance they purchased and obtain Medicaid coverage for care they needed after their private policies had ceased providing coverage. Four States (California, Connecticut, Indiana, and New York) have received DHHS approval to operate such programs. What impact this approach will have on the premium costs and marketability of private insurance for long-term care is unclear.

## Services, Eligibility, Management, and Financing

For those bills proposing new publicly funded or subsidized long-term care benefits, another set of issues must be resolved. These include: what services should be covered; what eligibility criteria should be used for determining who should receive benefits and how care for beneficiaries should be managed; what respective roles the Federal and State governments should play in the organization and management of the program; what provider reimbursement strategies should be used; and what financing mechanisms should be used.

**Covered Services.** Services that are generally considered critical services for chronically impaired elderly people to remain in their homes are nonmedical support services, such as homemaker/home health aide services, personal care, adult day care, and services that temporarily relieve family caregivers of their responsibilities (generally referred to as respite care). All recently considered bills proposing new publicly funded long-term care benefits are similar in the comprehensive coverage they would provide for home care. They do so because Federal programs currently provide relatively little support for home care, and these are the services most people prefer.

With regard to nursing home coverage, on the other hand, recent proposals have taken at least two distinct approaches. Certain proposals would provide comprehensive Federal coverage for the first months of a nursing home stay, for example, for the first 3 or 6 months of a stay. These proposals provide what is known as "front-end" coverage. Their emphasis is on providing comprehensive coverage for people during the first months of their stay so that after they return to the community their resources are intact. Those people with longer stays would use private funds or private insurance to pay for additional costs not covered by the public program.

Other proposals have been designed to offer more comprehensive Federal nursing home coverage than the previous approach. They would provide Federal coverage following a short stay of two or three months in a nursing home, with cost-sharing after benefits began. Private insurance could cover these costs.

This variation in approaches reflects, in part, the concern of certain policymakers that expanded nursing home coverage for long stays may end up protecting assets for some nursing home residents who are never likely to return to the community. The effect of the expanded coverage, financed with public dollars, may be to protect assets of the elderly for children or other relatives to inherit.

**Eligibility.** Bills proposing publicly financed benefits have based eligibility for long-term care benefits on a person's inability to perform ADLs, including the functions of bathing, dressing, getting in or out of a bed or chair, or eating. Using ADLs allows long-term care benefits to be targeted to a limited number of people, and also enables the new benefit to be provided without regard to certain medical criteria commonly used to establish eligibility for health benefits. Eligibility criteria for health benefits, such as prior hospitalization or need for skilled nursing care, often have little to do with the social service needs of a chronically impaired population and can limit access to services needed by a long-term care population. Proposals have generally used two or three limitations in ADLs as a threshold for eligibility, the higher number limiting eligibility to a more disabled population and covering fewer people. (As noted above, an estimated 3.3 million elderly require assistance with three or more ADLs.)

Recently considered bills have also based eligibility on the existence of cognitive impairments. Many people suffering from dementia or Alzheimer's disease may be cognitively impaired, and may not have limitations in ADLs, but require supervision to carry out these functions.

While surveys have estimated numbers of elderly with ADL limitations, the number of persons who would actually try to establish eligibility for new publicly financed benefits cannot be determined with any certainty. There is very little data on use of long-term care services in an insured environment. The great majority of elderly rely on family and friends to provide assistance with their needs. While studies have shown that families do not withdraw their support when expanded home and community-based care is provided under federally sponsored demonstration projects, information does not exist to show what demand for services would be when a program permanently establishes new publicly financed long-term care benefits. This lack of certainty about demand for care and resulting costs of new publicly funded benefits have served to postpone any major action on long-term care.

**Role of the States.** State governments have substantial responsibility for long-term care. Not only do States administer home and community-based services authorized under the Medicaid, SSBG, and Older Americans Act programs, they also have responsibility for implementation and oversight of Federal standards governing nursing homes and home health care agencies receiving reimbursement under the Medicaid and Medicare programs. Over the past 10-15 years, some States have made major strides in dealing with the complexities involved in coordinating the various

Federal home and community-based long-term care programs to overcome what they believe is a bias in Federal funding for institutional care.

State initiatives have included development of methods to control access to institutions through preadmission screening mechanisms; development of case management systems to authorize and control use of community-based services (sometimes through designation of local agencies to act as single entry points for long-term care services); and consolidation of State administration of the various long-term care services programs. In addition, some States have spent substantial State dollars to support home and community-based long-term care services to be responsive to the strong preference of the elderly for such care.

Some observers point out that a State role in the administration of an expanded publicly funded long-term care program may compromise a uniform national benefit, with the possibility of inconsistency in States' interpretations of Federal policies. Other analysts and State officials argue that States already have experience in coordinating and administering nonmedical long-term care benefits and are also in a good position to oversee the multiplicity of local providers that would be involved in providing long-term care.

Enacted legislation that has incrementally expanded nonmedical home and community-based services, such as the Medicaid waiver programs and the Older Americans Act, has built upon existing State roles. Recently considered proposals have provided for a major role for the States in administering new benefits, and it is likely that similar proposals will be considered by the 103rd Congress.

**Role of Case Management.** Case management generally refers to ways of matching services to an individual's needs. In the context of long-term care, case management generally includes the following components: screening and assessment to determine an individual's eligibility and need for a given service or program; development of a plan of care specifying the types and amounts of care to be provided; authorization and arrangement for delivery of services; and monitoring and reassessment of the need for services on a periodic basis.

Some State and local agencies have incorporated case management as a basic part of their long-term care systems development. The availability of Medicaid funds under the home and community-based waiver programs has spurred the development of case management services; but, other sources of funds have been used by States to develop case management systems, including State-only funds, SSBG, and the Older Americans Act.

Case management is carried out in a wide variety of ways. Organizational arrangements may range from centralized systems to those in which some case management functions are conducted by different agencies. Case management may be provided by many community organizations, including home health agencies, area agencies on aging, and other social service or health agencies. In some cases where statewide long-term care systems have been developed, one agency at the community level has been designated to perform case management functions, thereby establishing a single point of access to long-term care services.

While there seems to be a certain degree of consensus as to the promise case management offers as a means to control utilization of long-term care services as well as to coordinate services, there is not yet agreement as to the most effective way to incorporate case management functions into expanded long-term care benefits. Proposals have designated a number of different agencies to carry out some or all of the case-management functions.

**Reimbursement.** The way long-term care services are reimbursed will have a significant impact on expenditures under any new program. Medicare currently reimburses covered home health and nursing home services on the basis of reasonable costs (defined by the program) that have actually been incurred for care provided to program beneficiaries, up to specified limits. This method has been criticized on a number of grounds, including its lack of incentives for providers to maximize efficiency and minimize costs. Most States use, at least in part, a prospective payment method for reimbursing nursing home care under their Medicaid programs. Prospective payment reimbursement establishes, in advance of the time when services are provided, payment rates for care on a per visit, per case, per month, or other basis. Many long-term care proposals have required that reimbursement for community and/or nursing home care be based on annual budgets, fee schedules, or some other prospectively determined reimbursement mechanism, established by the Secretary.

Various Federal long-term care demonstrations have attempted to control payments for expanded home and community-based care by establishing caps on amounts that can be spent for services. Generally these have been linked to average Medicaid payments for nursing home care in the State, on the assumption that expanded services will serve as a substitute for institutional care and should cost less. The National Long-Term Care Channeling Demonstration, for example, required that average per client expenditures for expanded community-based care not exceed 60% of the average of the State's Medicaid rates for nursing homes in the demonstration area. Proposals have generally used some variation of this cap concept.

**Financing.** Bills proposing new publicly funded long-term care benefits recognize that new revenues would be required to finance these benefits. These new revenues are not insignificant, given the costs of proposals covering both nursing home and home care benefits. Certain bills providing coverage for nursing home and home care introduced in the 102nd Congress had estimated new Federal costs of $45-60 billion in the first full year of implementation. To finance new expenditures, bills variously propose increases in individual and corporate income taxes, increases in payroll taxes, including elimination of the cap on income subject to the Medicare payroll tax, increases in cigarette and alcohol taxes, and new estate taxes (on the grounds that expanded long-term care coverage under a public program protects assets that would be inherited by children or others). Bills that propose to provide tax incentives for the purchase of private insurance for long-term care also require new Federal expenditures, specifically tax expenditures that represent revenues lost to the Treasury. It is the tax burden associated with new long-term care benefits that has discouraged Congress from action in this area.

## LEGISLATION

**H.R. 132 (Collins)**

Long-Term Care Insurance Standards and Consumer Protection Act of 1993. Establishes a new Title XXI in the Social Security Act to require long-term care insurance policies to meet minimum standards specified in State regulatory programs approved by the Secretary of HHS. In the absence of approved State programs, policies would have to be certified by the Secretary. Requires policies to include nonforfeiture protection and to offer the option of inflation protection. Introduced Jan. 5, 1993; referred to Committee on Energy and Commerce.

**H.R. 438 (Wyden)**

Long-Term Care Insurance Consumer Protection Act of 1993. Amends Title XIX of the Social Security Act to require long-term care insurance policies to meet certain minimum standards specified in State regulatory programs approved by the Secretary of HHS. In the absence of approved State programs, policies would have to be certified by the Secretary. Requires policies to include inflation and nonforfeiture protection. Introduced Jan. 5, 1993; referred to Committee on Energy and Commerce.

**S. 203 (Kennedy)**

Long-Term Care Insurance Standards and Accountability Act of 1993. Amends the Public Health Service Act to require long-term care insurance policies to meet certain minimum standards specified in State regulatory programs approved by the Secretary of HHS. In the absence of approved State programs, policies would have to be certified by the Secretary. Requires policies to include nonforfeiture protection and to offer the option of inflation protection. Introduced Jan. 26, 1993; referred to Committee on Labor and Human Resources.

## FOR ADDITIONAL READING

U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action*, Final Report, Sept. 1990, Washington, D.C.

U.S. Congress, Congressional Budget Office, *Policy Choices for Long-Term Care*, June 1991, Washington, D.C.

## SUMMARY

Financing long-term care (LTC) services presents policymakers with a dilemma because the various goals of policy that many see as desirable are inherently inconsistent. In particular, containing the burgeoning total costs of LTC that are anticipated under current policies conflicts with providing better protection for LTC users against the out-of-pocket costs of this care, broadening the range of services available, and improving their quality.

Total LTC expenditures, and the amount that federal taxpayers fund under current law, are projected to rise rapidly because of the aging of the baby-boom generation, improvements in life expectancy, and rates of price increase for LTC services that exceed general inflation. Although medical research may be able to reduce future care requirements by finding ways to prevent the need for care, the policy dilemma will remain.

Some observers--"fiscal critics" of the present system--consider that both the level and expected growth rate of federal LTC costs are unacceptably high and that the private sector should therefore play a larger role in financing LTC services. Other observers--"performance critics" of the present system--consider that the system provides too little financial protection for people who need extended and, in many cases, very costly LTC services. They also want a broader range and higher quality of services to be available. Yet policy changes that would expand access to services and reduce the financial burden on individuals requiring them would in general increase total expenditures. Most changes would also raise federal outlays--perhaps by billions of dollars annually--beyond the increases projected under current law.

## BACKGROUND

Long-term care services are rehabilitative, medical, and supportive social services of various kinds for people who have functional limita-

Reprinted from Policy Choices for Long-Term Care. Washington, Congressional Budget Office, 1991. p. ix-xxii.

tions or chronic health conditions and who need ongoing health care or assistance with normal activities of daily living. These services include nursing home care and a range of home- and community-based (H&CB) services.

Although most people who need LTC receive it in the form of unpaid care from family members and friends, paid services are a big business that amounted to nearly $58 billion in fiscal year 1988 (see Summary Table 1). As the baby-boom generation ages, the LTC business will grow (see Summary Figure 1 for projected use of the principal form of care). Governments already pay half the total cost, mainly through the Medicaid program, and face the prospect of rapid growth in spending under current policy. Moreover, the prospects for avoiding the projected increases in federal outlays are bleak because the most effective mechanisms for doing so are already in place: individuals are now required to exhaust most of their own resources before receiving publicly subsidized care, the range of subsidized services is narrowly defined, and the states are already required to share in the costs of the Medicaid programs that they administer.

Complicating the challenge for policymakers is that the nature of the alleged problem of access to services in the current system is unclear. Despite anecdotal accounts of shortcomings in available LTC, there is little reliable quantitative evidence from nationwide studies showing that significant numbers of people fail to receive needed assistance. This dearth of evidence could imply that no real problem with shortages of LTC or unmet needs for LTC exists; it might, on the other hand, simply reflect a lack of consensus on what constitutes a "shortage" or on what is "needed" or "adequate" care. Finally, concerns about access might be of a quite different kind--reflecting, for instance, dissatisfaction with the financial terms on which access is currently available, or subjective evaluations of the scale, appropriateness, quality, or flexibility of care under the present system. Regardless of the nature of the access problem, however, a clear trade-off exists between modifying the LTC system to reduce individuals' financial vulnerability and the public and private costs of doing so.

### SUMMARY TABLE 1. ESTIMATED TOTAL SPENDING ON LONG-TERM CARE SERVICES BY TYPE OF SERVICE AND SOURCE OF PAYMENT, FISCAL YEAR 1988 (In billions of dollars)

| Payment Source | Nursing Home Care[a] | Home- and Community-Based Care[b] | Total |
|---|---|---|---|
| Total | 44.3 | 13.6 | 57.8 |
| Federal | 13.3 | 5.0 | 18.3 |
| Medicare | 0.9 | 2.4 | 3.3 |
| Medicaid | 11.5 | 1.3 | 12.9 |
| VA and other[c] | 0.9 | 1.2 | 2.2 |
| State and Local | 9.5 | 2.6 | 12.1 |
| Medicaid | 9.4 | 1.1 | 10.5 |
| Other[d] | e | 1.5 | 1.6 |
| Private | 21.5 | 6.0 | 27.5 |
| Out-of-pocket | 20.2 | 5.1 | 25.3 |
| Health insurance | f | 0.2 | 0.2 |
| Other[g] | 1.3 | 0.7 | 1.9 |

SOURCE: Congressional Budget Office calculations based on estimates from Actuarial Research Corporation.

NOTE: VA = Department of Veterans Affairs.

a. Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate nursing facilities, intermediate care facilities for mentally retarded people, and noncertified facilities providing some nursing care.

b. Home- and community-based care includes nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides and homemakers, medical social services, home-delivered and center-based meals, adult day care, senior centers, and transportation services.

c. Federal payments for home- and community-based care services are also provided under the Older Americans Act and the Social Services Block Grant.

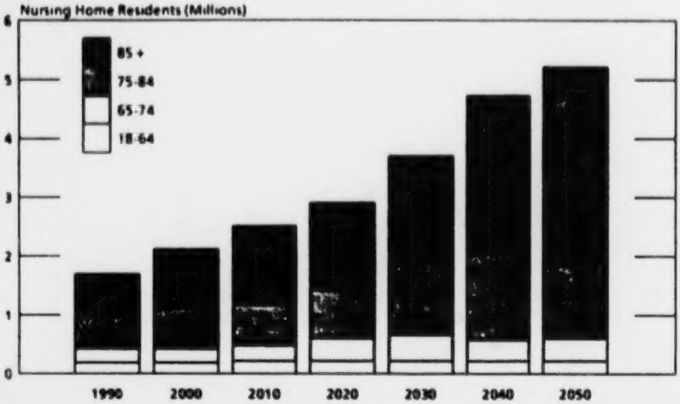
d. Other state funding includes Medicaid-related payments for which there was no federal matching and funding from state general revenues.

e. Less than $50 million.

f. Not separately identified. Included with "other private."

g. Other private sources of payment include private organizations and, for nursing home care, private insurance.

Summary Figure 1.
Projected Number of Nursing Home Residents, by Age of Resident and Year



SOURCE: Congressional Budget Office calculations based on middle series projections in Bureau of the Census, Current Population Reports, series P-25, no. 1018 (January 1989).

NOTE: The calculations assume that age-specific rates of use of nursing home beds will remain at 1985 levels.

## ISSUES

Long-term care policy might have several goals. It could aim to:

- Ensure that services are available, whether or not the people needing them can pay for them;
- Ensure that these services are of satisfactory quality;
- Protect individuals needing services against their potentially catastrophic costs; and

41[illegible]

- Avoid unnecessary federal outlays and contain their aggregate level.

People disagree, however, about the priority of these goals relative to other urgent fiscal concerns--not the least of which is reducing the federal deficit--and relative to one another. What weight, for example, should be given to the goal of providing financial protection against LTC costs? The Medicaid program is designed to address the goal of making LTC services available, but generally provides little protection for people's own resources because they remain ineligible until they have spent all but defined amounts of their resources on care.

## Issues Relating to Financial Protection for Individuals

Policymakers who wished to extend financial protection against the catastrophic costs of LTC would need to make four sets of choices in designing policies to do so. These choices concern the mechanism for providing financial protection, the range of services to be covered, the specific groups to be targeted for public assistance, and the division of responsibility between the public and private sectors and among the levels of government.

Selecting a Mechanism for Providing Financial Protection. The first choice would be to decide among alternative methods for providing protection against the high costs of LTC. Possible mechanisms include encouraging greater personal saving, establishing risk-pooling arrangements, providing subsidies that would be related to people's resources, or combining these strategies.

- Incentives to save are intended to augment personal resources and so to promote self-sufficiency in purchasing needed LTC services. These incentives, though, appear more likely to increase the net cost of LTC to the public sector than to reduce it.

- Risk-pooling arrangements would involve generally available insurance or prepaid care mechanisms through which nonusers and users of services at all income and asset levels could share the financial risks associated with LTC use. Unregulated private markets for LTC insurance, however, appear subject to market failure in ways that result in too little coverage.

- Resource-related subsidies, if used alone, would make LTC services available at subsidized prices for people with limited resources. A policy on user charges would specify how price subsidies would relate to the number of services used, the cost of each service, and the individual's level of privately available resources. The subsidies, however, would normally be financed by taxpayers.

- These three strategies could also be combined in various ways. In particular, combining risk-pooling arrangements with resource-related subsidies would create the option of subsidizing the participation of low-income people in any risk-pooling arrangements established for LTC. Subsidies for risk-pooling arrangements would also be borne by taxpayers.

Selecting the Services to be Covered. The second choice relates to the range of services for which financial protection would be offered. At issue are questions of balance within the overall mix of LTC services: balance between residential and nonresidential forms of care--for example, whether financial protection would be provided against the costs of all LTC services, or only nursing home care; balance within residential forms of care among nursing homes and other types of facilities that offer supportive or therapeutic care in a less restrictive setting; and balance within nonresidential forms of care among various in-home and community-based services.

Concerning the balance between residential and nonresidential forms of care, the critical policy question is the extent to which society is prepared to offer financial protection against the costs of H&CB care that may increase the quality of life for frail and functionally dependent people and their unpaid caregivers. This question is crucial because the evidence suggests that expanding conventional H&CB

programs would not reduce aggregate public LTC expenditures and could increase them considerably.

Targeting Assistance. The third choice concerns the specific groups toward whom public funds would be targeted if limitations on funding made such targeting the preferred approach. The possible criteria for defining target groups include age, duration of the need for services, the level of functional limitations, and the level of private resources available to LTC recipients or their families.

Assigning Responsibilities Within the LTC System. The fourth choice concerns how to divide responsibility within the LTC system among the private sector, state and local governments, and the federal government. Relevant areas of responsibility include determining the features of the LTC system, administering the system, and financing the paid care that is provided.

## Issues Relating to Total and Federal Costs

Virtually any LTC policy changes that would reduce financial vulnerability could be expected to increase total expenditures for LTC. They could also be expected to increase either federal outlays for LTC or the federal revenue losses associated with tax preferences for private LTC expenditures.

Policy changes to improve financial protection under voluntary arrangements would need either to increase the private resources available to purchase LTC services or to reduce the out-of-pocket cost of using services (which is the effective price of these services). Measures that would increase private resources--for example, tax incentives for private saving dedicated to LTC services--would probably reduce federal revenue by more than they would reduce Medicaid outlays. Measures that would reduce the out-of-pocket cost of using services would lead people to change--and in many cases to raise--the amounts, kinds, and quality of services they used in ways that would increase overall costs.

Increased private resources and lower effective prices for services would each increase use. If the supply of LTC services expanded less quickly, at least in the short run, then their prices would rise as well. Both effects would directly increase total costs and governmental costs. In addition, there could be indirect effects on costs. Attitudes toward the acceptability of paid LTC services might change, further increasing their use and cost, although the magnitude of these behavioral changes is unpredictable. Moreover, if accepted standards of care also rose, Medicaid would be expected to meet them, thereby indirectly increasing federal and state expenditures.

Proposals to improve financial protection need not expand the relative role of the federal government, however, although the absolute level of federal outlays or revenue losses would probably rise. For example, the federal government could continue to share program costs with the states in the same proportions as at present.

Historically, it appears that most growth in Medicaid's real spending on nursing home care has reflected growth in the number of days of nursing home care for which Medicaid paid rather than real growth in the cost of a day of care. In turn, growth in the number of nursing home days of care for which Medicaid paid appears to have resulted more from growth in days of care per recipient than from growth in the number of recipients.

## OPTIONS

Two broad approaches to modifying the LTC system are possible. One approach would retain both the current division of responsibility for LTC and Medicaid's basic character as an income-tested and asset-tested program. It would address specific problems in the design of the Medicaid program through changes that could be implemented incrementally, depending on priorities and the availability of funds. The other broad approach would more fundamentally restructure the systems for financing and delivering long-term care. In the process, it would substantially modify the division of responsibility for that care.

Numerous options are available under each approach. The Summary Box classifies many of these options by the extent and type of changes they would make in responsibilities within the LTC system.

## Incremental Options

Five illustrative options for changes in Medicaid would address various goals of LTC policy. Two of the options would increase both the availability of services and financial protection against their costs by establishing medically needy programs in all states and by broadening the availability of H&CB services for severely dependent people. Two additional options are designed to help contain net public outlays for LTC. One would tighten estate-recovery processes. The other would incorporate two approaches, whose effectiveness in containing program costs has been asserted but remains unproven. This option would regulate growth in the number of nursing home beds eligible for federal funding and extend the requirement for preadmission screening to a wider group of nursing home applicants. The remaining option could make a modest contribution to enhancing the quality of life for residents in nursing homes by raising and indexing the personal needs allowance, which enables Medicaid-eligible nursing home residents to make limited personal purchases.

Overall, these illustrative options could provide increased financial protection for a broader range of services, could make this protection more uniform across the states, and might increase the quality of life for some people needing LTC services. They would do so, however, at additional cost to taxpayers, and they would in some respects restrict the freedom of states to experiment and to determine the scope and structure of Medicaid in light of local conditions and values. They would also include features designed to contain costs that might prove ineffective or inimical to promoting both access and quality.

## SUMMARY BOX
## Illustrative Policy Options for Long-Term Care

**Implement Incremental Changes Within Medicaid**

- Mandate medically needy programs for LTC services
- Expand the availability of home- and community-based services for severely dependent people
- Tighten estate-recovery processes and rules
- Mandate state regulation of growth in the number of nursing home beds and preadmission screening for additional nursing home applicants
- Raise and index the personal needs allowance

**Expand Role of Private Sector**

- Introduce a refundable income tax credit for expenditures on private LTC insurance
- Require employers to arrange community-rated group LTC insurance coverage for employees and their family members and require employees to purchase it, possibly with a subsidy from employers or taxpayers
- Change the tax treatment of retirement income and insurance plans to facilitate combined insurance against the needs for retirement income, LTC, and income for survivors

**Expand Role of State Governments**

- Replace current federal LTC expenditures with an indexed block grant and transfer most policy and administrative responsibility for LTC to the states
- Replace current federal LTC expenditures with a block grant designed to grow in real terms and to help finance a state-administered system of case-managed care that would satisfy federal guidelines

**Expand Role of Federal Government**

- Establish social insurance offering comprehensive coverage
- Establish social insurance covering an initial period of care ("front end")
- Establish social insurance covering care after an initial period ("back end")
- Establish social insurance covering people with assets below the median level
- Establish social insurance covering nursing home care only

## Options that Would Substantially Modify the Division of Responsibility for Long-Term Care

Options that would more fundamentally restructure the financing and delivery of LTC can be grouped into three strategies. In essence, these strategies would expand the roles of the private sector, of the states, and of the federal government, respectively.

Expand the Role of the Private Sector. One strategy would provide public subsidies or regulatory support for participation in LTC financing arrangements that are under private auspices. This strategy would make greater use of the private sector--in providing or channeling funds to pay for services supplied by private organizations--but it would not necessarily reduce taxpayers' costs and could increase them. It could include subsidizing either private LTC insurance or private saving for LTC, while retaining a residual welfare program for people unable to secure needed care because they were poor or were denied insurance coverage on health grounds.

A refundable income tax credit for private LTC insurance, for example, would represent a flexible policy option that could substantially increase financial protection for those purchasing coverage and that might appreciably reduce Medicaid costs in the long run, although not necessarily by more than it would reduce tax revenues. Subsidizing private insurance for individuals, however, would not assist people with preexisting conditions that imply a current or future need for LTC, and it could require considerable regulation of the LTC insurance industry (which has yet to demonstrate either long-term commercial viability or large-scale consumer appeal). Moreover, the level of public subsidies--and hence of public expenditures--that would be required to achieve widespread insurance coverage under the option would almost certainly be large but cannot be quantified precisely.

Another option would require employers to arrange coverage for most employees and their family members under a community-rated, group LTC insurance policy with a standard package of vested, prefunded, indexed benefits that could be preserved by people leaving employment. Employees could be required to pay premiums from after-tax income with no public subsidy, or employees' premium payments could qualify for a refundable income tax credit as in the previous option, or any employer contributions could receive a degree of tax preference similar to that for employer pension contributions. This option could progressively establish widespread LTC insurance coverage. Because premiums would be community-rated, no one could be denied coverage because of preexisting conditions. Coverage would be achieved, however, by compelling LTC insurers to offer such coverage, employers to sponsor it, and employees to purchase it. Also, the federal government might in practice become the reinsurer of last resort, assuming ultimate financial liability if the insurance arrangements collapsed.

The illustrative option to promote saving for LTC, which can also be thought of as self-insurance, would make it easier for people to accumulate contingent assets (those that become available to their owners in defined circumstances). The option would change the tax treatment of retirement income and insurance plans to permit combined insurance against the needs for retirement income, LTC, and income for survivors. It would thus integrate private saving for LTC with the broader system of private saving for retirement income support. Cash benefits in the integrated system would then reflect health-induced variations in financial need among retirees. Providing benefits in cash, however, might lead to increased demand, more rapid growth in LTC prices, and cash payment for care that is currently unpaid. Moreover, information on which to base the levels of benefits and premiums in an integrated system is quite limited.

Expand the Role of the States. A second strategy would involve providing LTC block grants to the states in place of current federal LTC funding under Medicaid, Medicare, and portions of the Older Americans Act and the Social Services Block Grant. To qualify for the grants, state LTC programs would need to satisfy certain federal conditions. This option is compatible with a broad range of levels of federal financial commitment and policy responsibility for LTC. Federal funding under this option could vary from its present level, indexed only for inflation, to levels determined by a formula that could reflect the age structure of a state's population--for example, by incorporating progressively higher capitation rates for successively older cohorts--as well as the state's average per capita income. Similarly, conditions of the grant could vary from a mere requirement that states maintain their current inflation-adjusted funding levels for LTC to extensive provisions that would specify the minimum scope of coverage or requirements for LTC delivery systems.

This strategy would impose a predictable ceiling on federal outlays for LTC and would permit real growth in these outlays to be contained as desired. Some options under this strategy could dramatically lower federal costs compared with current law, but in doing so they would either transfer these costs to the states at a time when the population requiring LTC is expected to balloon or increase the costs being borne by those using LTC services and their families. Other options that involved higher levels of federal funding would enable the federal government to limit its outlays but retain significant influence over LTC policy. States might fear, however, that the federal financial commitment would be reduced after they had accepted greater financial, policy, and administrative responsibility for future systems of LTC.

Expand the Role of the Federal Government. A third strategy would involve a new social insurance program that would provide a legislatively based entitlement to defined LTC services for individuals assessed as having specified functional limitations. The most comprehensive option under this strategy would provide a full range of needed services to all people qualifying for the entitlement. Other options would adopt differing criteria to limit the scope of coverage and thus the implied increase in federal LTC costs. These criteria could limit coverage based on the duration of care (for example, covering only the "front end" or "back end" of care), the asset level of the care recipient (for example, covering only people with assets below the median level), or the type of care required (for example, covering only nursing home care).

By creating a new social insurance program, this strategy would spread the financial risks associated with the use of covered LTC across the whole population and would thereby provide a high degree of financial protection against the costs of this care. This approach would integrate not only the financing of LTC, but possibly also its delivery, and would provide all eligible people throughout the country with a similar opportunity to receive needed care.

The major drawback is that total federal LTC outlays would be much higher than under current law: more people needing LTC would qualify for assistance; a larger share of the services they received would be federally financed; people would seek more services than if they were paying fully for the care themselves; and the increase in demand could raise the unit price of LTC services. Moreover, assessment processes that were developed for research and clinical purposes, rather than as administrative criteria for determining an entitlement to benefits, would have a primary role in determining not only each individual's entitlement but also total spending on the program. People needing costly LTC services might characterize their problems more seriously to assessors who controlled access to the desired services. As a result, the number of people assessed as eligible for services under the entitlement could increase to an unknown degree. Consequently, public-sector costs under this strategy--especially for H&CB care--would not only be high but would also be subject to significant uncertainty.

# How Can the Federal Government Increase Access to Health Care to United States Citizens?

## An Annotated Bibliography on the 1993-1994 High School Debate Topic

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# NATIONAL HEALTH CARE:

## HOW CAN THE FEDERAL GOVERNMENT INCREASE ACCESS TO HEALTH CARE TO UNITED STATES CITIZENS?

This bibliography provides citations to assist high school debaters with research on the 1993-1994 high school debate topic on National health care. This bibliography is divided into four major sections, representing the general debate topic and the three specific resolutions. Each citation is listed only once. Therefore, debaters are encouraged to scan related sections because of the interrelatedness of this topic.

Monographs, journal and magazine articles, congressional publications, and reports from 1989 to the present are included. The majority of the citations were obtained from the computerized bibliographic database created and maintained by the Congressional Research Service's Library Services Division. Other materials were selected from the collections of the Library of Congress and the Congressional Research Service.

The General section addresses the problem of access to health care. It also treats the different population groups involved before considering policy alternatives. The second section includes material on the uninsured, national health insurance, comparative and foreign health systems, and proposals to improve access to health insurance. The third section focuses on the rise of health care costs and what should be done to control costs in the future. The final section includes material on catastrophic illnesses, Medicare's Catastrophic Health Insurance Act of 1988, and long-term care. The last section contains earlier materials dating back to the early 1980s, when catastrophic coverage was of major concern.

This bibliography is not intended to serve as a comprehensive list of all resources in the field of health care. It is an introduction to materials available on the debate topic. Many of the items included in this bibliography contain footnotes or their own bibliographies; these can be effective tools for finding supplementary material.

More information on all of these subjects can be obtained through further library research. A CRS prepared research guide follows the bibliography, with basic information for finding additional material.

The author wishes to thank her colleagues in the Congressional Research Service for their help in the preparation of this bibliography. Thanks are also extended to Edith Sutterlin, Library Services Division; Nonna A. Noto, Economics Division; Fran Larkins, Congressional Reference Division; and Janet L. Kline, Section Head, and analysts Edward R. Klebe, Beth C. Fuchs, Mark Merlis, Jennifer O'Sullivan, and Richard Price, Health Section, Education and Public Welfare Division, for their review of this product. Allison Level, Science Reference librarian, Library of Congress, also provided valuable assistance.

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# NATIONAL HEALTH CARE: HOW CAN THE FEDERAL GOVERNMENT INCREASE ACCESS TO HEALTH CARE TO UNITED STATES CITIZENS?

## I. GENERAL

Aaron, Henry J.
Looking backward: 2001-1991: the history of the Health Care Financing and Reform Act of 1988. Brookings review, v. 9, summer 1991: 40-45.

"The start of the new millennium is an appropriate time to look back at the enactment of one of the twentieth century's most important pieces of social legislation, the Health Care Financing and Reform Act of 1988. This statute, which will shape U.S. health care policy for much of the 21st century, promises to achieve two long-sought but elusive goals--assuring access to health care for all Americans and controlling explosively rising health care cost."

-----
A prescription for health care. In Setting national priorities: policy for the nineties. Henry J. Aaron, editor. Washington, Brookings Institution, 1990. p. 249-291.

Recommends a health financing program for the nineties. "To achieve universal coverage, the federal government would first mandate coverage for workers with significant attachment to the labor force and for their immediate families . . . . Second, a backup plan providing the same benefits required of employer-sponsored plans would be provided for all those not covered at work. This plan would cover the elderly and disabled who are currently covered by medicare . . . . Third, the burden of controlling costs would rest with regional, state, or local organizations ('finance agents') charged with negotiating physicians' fees and hospital budgets for all payers, private as well as public."

Access to medical care for Black and White Americans. JAMA [Journal of the American Medical Association], v. 261, Jan. 13, 1989: 278-281.

"A 1986 national survey of use of health services shows a significant deficit in access to health care among black compared with white Americans. This gap was experienced by all income levels of black Americans. In addition, the study points to significant underuse by blacks of needed medical care. Moreover, blacks compared with whites are less likely to be satisfied with the qualitative ways their physicians treat them when they are ill, more dissatisfied with the care they receive when hospitalized, and more likely to believe that the duration of their hospitalization is too short."

Access to prenatal care following major Medicaid eligibility expansions. JAMA [Journal of the American Medical Association], v. 269, Mar. 10, 1993: 1285-1289.

Found that "lack of private insurance was a strong risk for no [prenatal] care." Financial barriers proved difficult for medical patients as well as the uninsured, and often resulted in delayed initiation of prenatal care, even when it was available.

Aday, Lu Ann.
At risk in America: the health and health care needs of vulnerable populations in the United States. San Francisco, Jossey-Bass Publishers, 1993. (The Jossey-Bass health series)

This book will be available later in 1993.

Adolescent health. Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1991. 3 v. (188, 762, 303 p.)

Contents.--Vol. I: Summary and policy options.--Vol. II: Background and the effectiveness of selected prevention and treatment services.--Vol. III: Crosscutting issues in the delivery of health and related services.

AHCPR purpose and programs. Washington, U.S. Public Health Service, 1990. 14 p.

"The purpose of the Agency for Health Care Policy and Research (AHCPR) is to enhance the quality, appropriateness, and effectiveness of health care services and to improve access to that care. Created in December 1989, AHCPR is the Federal Government's focal point for medical effectiveness and health services research."

American health policy: critical issues for reform. Edited by Robert B. Helms. Washington, AEI Press, publisher for the American Enterprise Institute, 1992.

American Medical Association.
Health access America: the AMA plan to reform America's health care system. Second edition. Chicago, American Medical Association, 1990. 22 p.

"Since announcing Health Access America, we have actively discussed our plan with the government, other health care organizations and interested groups, and representatives of labor, business, and the insurance industry. In response to the national dialogue, we have modified our plan to incorporate important refinements. This second edition of Health Access America incorporates changes based on attentive listening to all sides of the health reform debate."

American Medical Association. Council on Ethical and Judicial Affairs.
Black-white disparities in health care. JAMA [Journal of the American Medical Association], v. 263, May 2, 1990: 2344-2346.

"Persistent, and sometimes substantial, differences continue to exist in the quality of health among Americans. Blacks have higher infant mortality rates and shorter life expectancies than whites. Underlying the disparities in the quality of health among Americans are differences in both need and access."

America's health care: which road to reform? Yale law & policy review, v. 10, no. 2, 1992: 205-487.

Partial contents.--Introduction, by Sen. Harris Wofford.--Making sense of the national health insurance reform debate, by Theodore Marmor and Michael Barr.--Evaluating the cost of health-care reform plans.--The Canadian health-care financing and delivery system.--Hawaii and Massachusetts: lessons from the States, by Michael S. Dukakis.--Light on the black box of basic health care: Oregon's contribution to the national movement toward universal health insurance.--Improving the quality of medical care.--Granny dumping: the hospital's duty of care to patients who have nowhere to go.

Annis, Edward R.
Code blue: health care in crisis. Washington, Regnery Gateway, 1993.

This book will be available later in 1993.

Balancing access, costs, and politics: the American context for health system reform. John Holahan, et al. Washington, Urban Institute Press; Lanham, MD, Distributed by University Press of America, 1991. 79 p. (Urban Institute report, 0897-7399; 91-6)

Bergthold, Linda.
Purchasing power in health: business, the state, and health care politics. New Brunswick, Rutgers University Press, 1990. 213 p.

Berwick, Donald M. Godfrey, A. Blanton. Roessner, Jane.
Curing health care: new strategies for quality improvement: a report on the National Demonstration Project on Quality Improvement in Health Care. San Francisco, Jossey-Bass, 1990. 287 p. (The Jossey-Bass health series)

Bishirjian, Terry.
Rural health care in the 1990s: decade of decision and change. Appalachia, v. 22, spring 1989: 31-37.

Addresses the challenges facing Appalachian health care in the near future: costs, competitiveness, accessibility, affordable insurance, skilled medical professionals, and geographical barriers.

Blackshears, Edward. Craft-Blackshears, Melva.
The Black family: impact of economics & health care. Edited by Reginald McGhee, Jr. Detroit, Mich., PC Print Pub., 1990. 82 p.

Bodenheimer, Thomas.
The way to real health security: public or private? Nation, v. 253, Dec. 16, 1991: 772, 774-776.

"How do we solve the two-part health crisis, the crisis of access and the crisis of cost? Our nation must choose between . . . the 'private insurance reform package' and the 'health security approach' . . . . Do we join the rest of the civilized world and provide health services to everyone at a cost we all can afford, utilizing the well-recognized principle of universal public insurance?"

Brooks, Duraldo D. Smith, David R. Anderson, Ron J.
Medical apartheid: an American perspective. JAMA [Journal of the American Medical Association], v. 266, Nov. 10, 1991: 2746-2749.
Observes "functional apartheid" in medical care and medical economics in the United States, resulting in a poorer health status and higher mortality rate for American minorities. Notes differences and similarities with problems in the South African health care system.

Budetti, Peter P.
Achieving a uniform Federal primary care policy: opportunities presented by national health reform. JAMA [Journal of the American Medical Association], v. 269, Jan. 27, 1993: 498-501.
Urges "explicit consideration" be given to developing a coherent primary care policy. Identifies obstacles within four categories: education and training, physician payment, the service delivery system, and research.

Burgess, James F., Jr. Stefos, Theodore.
Federal provision of health care: creating access for the underinsured. Journal of health care for the poor and underserved, v. 1, spring 1991: 364-387.
"The federal health care system for veterans is used as a model for exploring problems that must be solved in a universal access plan. The discussion focuses on the effects of competition for patients and health care resources on costs, innovation, regulation, and quality."

Burke, Marybeth.
Comprehensive vs. incremental reform: the debate intensifies. Hospitals, v. 66, Mar. 20, 1992: 38, 40, 42.
"President Bush's entry last month into the health care reform fray with his own reform proposal has officially triggered a partisan call to arms. It has also intensified the current debate over whether the U.S. health care system requires incremental or comprehensive reform."

Business leaders' views on American health care. Health affairs, v. 10, spring 1991: 98-105.
"This survey of 384 top executives of the nation's largest companies--employing ten million individuals--reveals a nascent political will among business leaders to proceed with major changes in the health care system. Pressure from rising costs of providing health care coverage to their workers may be the single most important factor stimulating executives' current high level of interest in system reform."

Butler, Charles F. Addicott, James W.
Dignity or despair: health care in the United States. San Jose, Calif., Financial Arena, 1989. 202 p.

Butler, Stuart.
Freeing health care. National review, v. 41, Dec. 22, 1989: 34-36.
"Conservatives should not deny the goal of access to affordable health care, as they have done in the past. Instead, they should argue that only by changing direction completely, introducing a real market in health care rather than trying to suppress all vestiges of pricing and competition, will Americans ever achieve affordable health care for all."

Care and cost: current issues in health policy. Edited by Kenneth McLennan and Jack A. Meyer. Boulder, Westview Press, 1989. 231 p. (Westview special studies in health care and medical science)
"A publication of the Committee for Economic Development."

Challenges and opportunities: issues facing the U.S. health care system. Washington, Employee Benefit Research Institute, 1991. 26 p. (EBRI special report, SR-13)
Focuses on "costs, quality, and access." Includes statistical information on national health expenditures, barriers to access, and the identity of the uninsured.

Changing U.S. health care: a study of four metropolitan areas. Eli Ginzberg, Howard Berliner, Miriam Ostow, and associates, et al. Boulder, Westview Press, 1992. (Conservation of human resources studies in health policy)
Municipal Health Services Program (U.S.)
This book will be available later in 1993.

Clancy, Frank.
Rural RX. Harrowsmith, v. 7, Mar.-Apr. 1992: 31-37.

Describes how, despite "a dire shortage of physicians, nurses and other health care workers in rural areas," Barrett Memorial Hospital in Beaverhead County, Montana, has successfully pioneered a low-birthweight-prevention program and other public health innovations to survive in the future.

Cohen, Jill.
Access to medical care for HIV-infected individuals under the Americans with Disabilities Act: a duty to treat. American journal of law and medicine, v. 18, no. 3, 1992: 233-250.

"Uncovers Congress's intent to impose a duty on health care providers to treat people with disabilities unless an individual poses a 'direct threat' to the health or safety of others."

Colon, P. A. Colon, A. R.
The health of America's children. In Caring for America's children. New York, Academy of Political Science, 1989. p. 45-57.

"Poverty will continue to have a strong effect on the health and well-being of the nation. Other issues that involve millions of Americans are access to health care, the utilization of health-care facilities, and the response to health-education programs. No less than a national referendum is called for in a commitment of all citizens to participate in bequesting a healthy future to our children."

Connelly, Julia E.
Medical care in rural America. World & I, v. 6, June 1991: 569-581.

"The lack of physicians is a common ocurrence in many rural communities across America and limits access to medical care."

The Crisis in health care: costs, choices, and strategies. Dean C. Coddington, et al. San Francisco, Jossey-Bass Publishers, 1990. 303 p. (The Jossey-Bass health series)

The Crisis in health care: ethical issues. Edited by Nancy F. McKenzie. New York, Meridian, 1990. 640 p.

Crisis in medical care. Journal of State government, v. 64, July-Sept. 1991: whole issue (73-100 p.)

Contents.--Options for State health policy: alternative benefit designs, by John Begala, Sandra Kuehn and Cathy Levine.--Private-public partnerships to expand health care access, by Trish Riley.--Public data and private doctors: Maine tackles treatment variations, by Robert B. Keller.--Strategies for controlling health care costs, by National Governors' Association staff.--The South accepts the challenge, by Tamara Lucas Copeland.--The genes puzzle, by Robert A. Weinberg.--The State response to genetic research, by R. Stephen Brown.

Crisis in the U.S. health care system: how should government and industry respond? Washington, MAPI, 1989. 31 p. (MAPI policy review PR-108)

"Examines the current U.S. system of health care delivery and its problems. The mandated benefit proposal, as contained in S. 768 [Basic Health Benefits for All Americans Act], is then reviewed, and finally, alternative approaches to improving access to health care without further escalation of costs are discussed."

Danker, Harold.
Health policy issues for the 1990s. National tax journal, v. 43, Sept. 1990: 293-298.

"Attempting to address and solve the problems of the health care system will take strong political commitment and the active participation of all interested parties in finding a solution. Meaningful solutions must be based on a broader understanding of why the problems exist, and why they are likely to worsen if nothing is done. Only then can and should we proceed to find solutions, whether incremental or more comprehensive in nature."

Delivering essential health care services in rural areas: an analysis of alternative models. Rockville, Md., U.S. Public Health Service, 1991. 60 p. (AHCPR pub. no. 91-0017)

"In many rural communities, the survival of small hospitals is in jeopardy because they are no longer able to meet the financial and legal requirements of a traditional full-service facility. The closure of the sole hospital in these communities would seriously limit access to essential health care services. In order to maintain access to essential health care services for rural residents a number of States and communities are converting closed or failing rural hospitals into alternative kinds of health facilities. This analysis examines six of these alternative models. Three of the models maintain acute care inpatient beds for stabilization and holding capacity; the other three models eliminate all acute care beds. These models can provide important examples to policymakers, health professionals, and consumers of health services who seek to create more appropriate health care delivery and financing systems for rural areas."

Dentzer, Susan.
America's scandalous health care: here's how to fix it. U.S. news & world report, v. 108, Mar. 12, 1990: 24-28, 30.

"A nation that leaves so many citizens unprotected from the ravages of illness is clearly depriving them of the pursuit of happiness--and at times, even of life itself. Outrage over these ills may prompt the most radical surgery ever conducted on the fractured health system."

Eddy, D. M.
What care is 'essential'? What services are 'basic'? JAMA [Journal of the American Medical Association], v. 265, 1991: 782-788.

Ellwood, Paul. Etheredge, Lynn. Enthoven, Alain.
The 21st century American health system. Jackson Hole, Wyo., The Jackson Hole Group, 1991-1992. 27 p.

Contents.--Overview and accountable health partnerships, [Sept. 3, 1991].--Market reform and universal coverage [Rev. Mar. 20, 1992].--Uniform effective health benefits [Aug. 30, 1991].--The public-private health partnership and the National Health Board [Sept. 4, 1991]. These initiatives assume that medical providers and insurers will "assume responsibility for the kind of internal restructuring that is crucial to what will become the new competitive bottom line in health care: public accountability for health care's impact on patient satisfaction, function, and wellbeing, all at a reasonable cost."

Emmott, Carol B. Wiebe, Christine.
The unraveling safety net. Issues in science and technology, v. 6, fall 1989: 51-55.

Describes the effect that Federal cost cutting has had on public hospitals. Indicates that without help, these hospitals which serve the medically uninsured will not be able to continue caring for patients.

Ethics and Medicaid: a new look at an old problem. Journal of health care for the poor and underserved, v. 2, spring 1992: 427-447.

"Recent proposals to reform Medicaid, driven primarily by the need for cost containment, rarely pay explicit attention to values. This paper presents the Medicaid Values Framework, the authors' interpretation of a set of societal ideals embodied in Title XIX of the Social Security Amendments of 1965. The Framework comprises seven interlocking values that are stratified into three interdependent tiers--access, quality, and equity. We use the access and equity tiers to analyze treatment of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) recipients under Medicaid. We document striking inequities in eligibility standards and in funding for the two groups--inequities that unexpectedly fail to translate into marked disparities in access to Medicaid. In conclusion, we comment on why the present inequities exist and why they are ethically unacceptable."

Faltermayer, Edmund.
Let's really cure the health system. Fortune, v. 125, Mar. 23, 1992: 46-50, 54, 58.

"The country's best hope for insuring everyone while keeping overall health spending within reason is to harness the growing public pressure for reform to a plan that could transform this flawed system into the Toyota City of world health care. Only market forces, which drive and discipline most other sectors of the economy, can bring about this industrial revolution."

Federal, State health care reform activity. Employee benefit plan review, v. 47, Feb. 1993: 42-51.

Cover title.

Partial contents.--Washington insiders discuss reform, by Margaret Keefe.--Unemployment comp to be used to fund uncompensated care.--Florida proposes managed competition for State health reform.--States propose 2,000 reform measures, ERISA stands in way.--Employers prefer Federal reform to State initiatives.

Feldstein, Paul J.
An economic perspective on health politics and policy. Quarterly review of economics and business, v. 30, winter 1990: 117-135.

"This article uses a self-interest model to explain health care legislation. Seemingly uncoordinated, contradictory, inefficient, and inequitable legislative outcomes are shown to be the result of a rational process in which the participants, including legislators, act according to their calculation of costs and benefits. Those groups able to offer political support receive net benefits at the expense of those who are less politically powerful. This framework is used to examine different types of health legislation with the emphasis on explicit redistributive policies such as Medicare and Medicaid."

Foster, Stuart A. Gorr, Wilpen L.
Federal health care policy and the geographic diffusion of physicians: a macro-scale analysis. Policy sciences, v. 25, May 1992: 117-134.

"The federal government passed legislation in the 1960's and 70's to increase physician supplies and reduce spatial inequalities in access to physicians. A major policy was to aggressively continue increasing the overall supply of physicians on the assumption that market forces would eventually divert physicians from areas of high physician density to those of low density. Using state-level, annual data collected over a 21-year period, this paper investigates the macro-scale spatial diffusion of physicians as an essential element in evaluating this policy. The results provide evidence of the policy impacting locational trends relating to primary care physicians, but not specialists. They also indicate that the Medicaid/Medicare programs may have adversely affected the maldistribution problem."

The Future of health care: public concerns and policy trends. Edited by Elliot M. Stone. Waltham, MA, Massachusetts Health Data Consortium [1991] 128 p. (Health policy series.)

A Publication of the community awareness series

"A Transcript of the seminar series"--Cover. Contains six Consortium's health policy seminar papers held from Apr. 1989 to June 1990.

Garland, Susan B.
A prescription for reform. Business week, no. 3234, Oct. 7, 1991: 58-63, 66.

"There are a thousand agendas in Washington, but if any issue dominates the lists, it is health care reform. After countless years of neglect, its time has come. The cries from employers beleaguered by soaring costs have reached a crescendo that politicians dare not ignore. Those cries are matched by the rage of more and more working Americans as they helplessly watch their coverage dwindle, or even disappear. The result: an overhaul of the health care system looms as a major--maybe the major--issue of 1992."

Ginzberg, Eli.
A century of health reform. Society, v. 30, Nov.-Dec. 1992: 19-25.

Protests that recent presidents "have been silent about our historic commitment to 'equality of opportunity' for every American child and adult. Significant health reforms are not very likely to be implemented until the United States remembers 'E Pluribus Unum.'"

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The medical triangle: physicians, politicians, and the public. Cambridge, Mass., Harvard University Press, 1990. 314 p.

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US health care policy in 1990: looking back, looking ahead. Quarterly review of economics and business, v. 30, winter 1990: 15-22.

"Health policy in the United States is best understood as a policy of incrementalism with major interventions occurring only in response to crisis, as in the case of the Medicare legislation that profoundly altered our historic financing of health care. The characteristically minor, unplanned, adjustments that are made often have major unanticipated consequences, and these serve to explain the radical transformation of the nation's health system in the half-century since World War II."

Goodman, John C. Musgrave, Gerald L.
Patient power: solving America's health care crisis. Washington, Cato Institute, 1992. 673 p.

Gordon, Colin.

*Health care the corporate way. Nation, v. 252, Mar. 25, 1991: 376, 378-380.*

"Almost everyone now agrees that something is terribly wrong with the way health care is provided (or not provided) and paid for in the United States. But if the short-term goals and self-interest of American business carry their usual weight in Washington, health care reform will begin with a large step in the wrong direction."

Gordon, John Steele.

How America's health care fell ill. American heritage, v. 43, May-June 1992: 49-52, 54, 56, 58, 60, 62, 65.

Describes changes in medicine and health care in the past century. Complains that "as modern medicine has grown ever more powerful, our ways of providing it and paying for it have gotten ever more wasteful, unaffordable, and unfair."

Gordon, Judith A. Hunsaker, Keith A., Jr.

Employer strategies for modifying or terminating retiree benefits in the 1990s. Employee relations law journal, v. 18, winter 1992-1993: 413-436.

"Over the past decade, access to health care coverage has become a crucial national concern. At the same time, the rising cost of health care, the aging of the population, and new accounting requirements for retiree medical benefits have caused employers to reevaluate their commitment to providing unrestricted health care benefits to the retirees. This article discusses the key federal appellate court decisions concerning an employer's decision to modify or terminate retiree medical benefits. It then explores alternatives for meeting the statutory, legal and accounting challenges faced by employers who now offer retiree health care coverage."

Haislmaier, Edmund F.

The health care quagmire. Consumers' research, v. 72, Sept. 1989: 10-16.

"There is a growing concern in America that the nation's health care system needs intensive care. The most obvious problems are the rapid escalation in the cost of medical care and, in part as a result of such high costs, the fact that many Americans effectively are denied access to necessary medical treatment."

Health access America--strengthening the US health care system. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2503-2506.

"Although Americans remain generally satisfied with the health care provided to them, sufficient access to high-quality, affordable health care for citizens without health care insurance has become an increasing problem in the last decade. Using the policy development process of the American Medical Association, Health Access America was conceived by the association to improve access to affordable, high-quality health care. The proposal consists of six fundamental principles and 16 key points. This article specifically focuses on the five points that, if enacted into law, would improve access to health care for Americans who are, for various reasons, without health insurance."

Health care. Roll call, v. 38, Feb. 1, 1993: 21-42. (Policy briefing no. 49)

Members and health policy analysts write about reform.

Partial contents.--Congress and President can do it this year.--We quite literally cannot afford not to reform our health care system.--Health care reform begins in the States.--Congress, not President Bush, should be blamed for inaction on health care reform.--Don't leave vets out of the debate.--In praise of managed competition.--How pharmacists can help.

Health care. State Government news, v. 35, June 1992: 15-30.

Contents.--Medicaid diet plans, by Elaine S. Knapp.--Setting priorities in Oregon.--Rebirth of a good idea, by Linda Wagar.--The AIDS factor, by Theresa Raphael.--Health checkup: measuring the nation's vital signs on health care, by Linda Wagar.--An epidemic in check, by Dag Ryen.

Health care; a leading concern for Americans, a leading challenge for policy makers. Washington, Campaign for Women's Health, A Project of O.W.L., 1991. 4 p.

This fact sheet on women's health needs was distributed at and presented to the Task Force on Opportunities for Research on Women's Health, National Institutes of Health, June 12, 1991. "The Campaign's work includes analyses of present and proposed health policy, advocacy at state and federal levels of government, and a nationwide public education effort."

Health care crisis. USA today (magazine), v. 120, Mar. 1992: 20-28.

Contents.--How to end the health care crisis, by Marty Russo.--Myths of long-term health care, by Robert Fain.--Managed care: an answer for America's health care crisis, by Malik Hasan.--Can we put the brakes on health care costs? by Louis W. Sullivan.

Health care crisis. U.S. news & world report, v. 113, Nov. 23, 1992: 26-27, 28, 30, 33, 36-39.

Contents.--Clinton's big test: The fate of the budget, the economy and his first term rests on containing medical costs, by Susan Dentzer.--Why the prognosis for reform is poor: a look at hospitals and communities shows how tough it will be to control medical costs, by Jerry Buckley.

Health care in America: is there a cure? World & I, v. 7, June 1992: 20-51.

Contents.--What's right and wrong with U.S. health care, by James A. Rice.--The uninsured, by John C. Goodman.--The play or pay plan, by Harvey I. Sloane.--The Canadian and German models, by Theodore R. Marmor.--The President's proposal, by Elise D. Smith.--A consumer choice health system, by Edmund F. Haislmaier.--Medical savings accounts, by John C. Goodman.

Health care in rural America. Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1990. 529 p.

"OTA-H-434"

Partial contents.--an Overview of rural population and health programs.--Availability of rural health services.--Availability of rural health personnel.--Maternal and infant health services.--Rural mental health care.

A 26 page executive summary is available in the reading guide portion of this manual.

Health care reform. Hospitals, v. 66, Jan. 20, 1992: 32-37, 40-46, 48, 50.

Contents.--Health care: reform a priority in the new legislative year, by Marybeth Burke.--Local governments cope with Medicaid, work for reform, by Terese Hudson.--A decade of competition ends--a new era of cooperation begins, by Dick Davidson.--Health care reform tops the AHA's list of priorities, by Richard J. Pollack.--Advocacy through the courts: the AHA's legal strategy, by Fredric J. Entin.

Health care reform. Hospitals, v. 67, Jan. 20, 1993: 16-20, 22-27.

Partial contents.--Thirteen views from the Hill: congressional leaders paint varying reform scenarios.--Networks and our next step: communicating the hospital community's vision on reform.--Clinton's next moves.--Health care reform: the path to enactment.--The new Congress.

Health care reform: collected articles. Business & health, v. 10, Sept. 1992: 24, 26-27, 29, 31-38, 40-44, 46-52.

Contents.--While Congress debates, the States legislate, by Kenneth M. Coughlin.--Oregon continues to push its health care reform plan, by Gregory Jordahl.--Presidential candidates' propose health care platforms, by Joyce Frieden.--Health reform plans adapted from Jackson Hole vie for support, by Rosalind Resnick.--Lobbyists want to limit Federal intervention in health care, by Joyce Frieden.--Massachusetts' "miracle" reform plan stalls, by Eric Zicklin.--Politics aside, three employers join forces, by Rosalind Resnick.

Health care reform: tradeoffs and implications. Washington, Employee Benefit Research Institute, 1992. 59 p. (EBRI issue brief, no. 125)

"Describes reform proposals and examines how each proposal would affect the coverage, costs, and quality of health care. It explores what reform will mean for employers, individuals and providers."

Health policy: a special report. American enterprise, v. 3, Jan.-Feb. 1992: 58-75.

Contents.--Why is American health care so hard to reform? by Mark V. Pauly.--Mandates: what most proposals would do, by Michael A. Morrisey.--The search for a better approach, by C. Eugene Steuerle.--Other models and hidden costs, by Patricia M. Danzon.

Health policy and the disadvantaged. Edited by Lawrence D. Brown. Durham, Duke University Press, 1991. 212 p.

Health policy and the Hispanic. Edited by Antonio Furino. Boulder, Westview Press, 1992. 240 p.

Health politics and policy. [Edited by] Theodor J. Litman and Leonard S. Robins. 2nd ed. Albany, N.Y., Delmar Publishers, 1991. 484 p. (Delmar series in health services administration)

Hellman, Sandra.
Health care in the year 2000 and beyond. Futures research quarterly, v. 7, spring 1991: 67-83.

"What will health care look like in the year 2000 and beyond? There have been hundreds of articles written about the future of health care, some based on sound research, others stating opinions of experts in the field. The goal of the study reported here was to identify the commonalities in these predictions and to develop a conceptual description from a synthesis of this material. Several variables have been identified in the literature as having a significant impact on the future of health care. The attempt was made here to review all of these important variables."

Hospital closures and access to medical care. Lexington, Ky., Council of State Governments, 1989. 11 p. (CSG backgrounder 078901)

"There is much debate concerning the economics of our nation's health care system, and whether these hospital closings are the result of unfair regulation practices, the health industry's own glut, or poor fiscal management. The purpose of this paper is not to argue these points, but to address the occurrence of hospital closings as a concern for state and local officials who must deal with the consequences as they affect public access to medical care."

The Impact of HIV on communities of color: a blueprint for the nineties. Washington, National Minority AIDS Council, 1992. 59 p.

"The legacy of discrimination against communities of color obstructs cooperative efforts with government bodies. Lack of demonstrated commitment to secure access to health care for communities historically burdened with poverty, addiction, infant mortality and premature morbidity exacerbates that distrust .... In order to help establish an atmosphere of trust, the U.S. Government must demonstrate a commitment to accessible health care for historically underserved communities. It must include full participation by communities of color at all policy and decision-making levels."

Improving health policy and management: nine critical research issues for the 1990s. Edited by Stephen M. Shortell and Uwe E. Reinhardt. Ann Arbor, Mich., AHSR/HAP, 1992. 505 p.

The Baxter health policy review

"Research syntheses from the Foundation for Health Services Research."

Institute of Medicine (U.S.). Committee on Monitoring Access to Personal Health Care Services.
Access to health care in America. Edited by Michael Millman. Washington, National Academy Press, 1993. 229 p.

"The focus of this report, like the committee's deliberations, is on access to personal health services--the one-on-one interaction of provider and patient. The committee chose five objectives of personal health care to organize its indicators: successful birth outcomes, reducing the incidence of preventable diseases, early detection and diagnosis of treatable diseases, reducing the effect of chronic diseases and prolonging life, and reducing morbidity and pain through timely and appropriate treatment."

Intergovernmental focus on health care. Intergovernmental perspective, v. 18, spring 1992: whole issue (39 p.)

Contents.--Medicaid reform: major trends and issues, by Elliot J. Dubin.--Medicaid and health care reform, by Henry A. Waxman.--Medicaid: successes, failures, and prospects, by Jane Horvath.--Medicaid recipients: the forgotten element in Medicaid reform, by Michele Melden.--Long term U.S. health care reform: three approaches, by D. William Graham.--Health care reform: the State perspective, by Booth Gardner.--Implications of the Medicare fee schedule for Medicaid, by David C. Colby.

Jacobs, Lawrence R.

The health of nations: public opinion and the making of American and British health policy. Ithaca, N.Y., Cornell University Press, 1993.

This book should be available later in 1993.

Kelleher, Kevin C.

Free clinics: a solution that can work . . . now! JAMA [Journal of the American Medical Association], v. 266, Aug. 14, 1991: 838-840.

"With no federal support and little local governmental support, there are over 200 free clinics in the United States, many with 15-year histories. They are functioning with little networking and have developed independent solutions to the problem of providing care to the uninsured."

King, Martha P.

Maternal and child health care legislation: 1991. Washington, National Conference of State Legislatures, 1991. 87 p.

"Maternal and Child Health Legislation: 1991 summarizes 350 laws and resolutions pertinent to maternal and child health issues passed by the 50 states, the District of Columbia, and Puerto Rico. Topics include: access, accidents, safety, financing, health education, immunization, insurance, lead poisoning, Medicaid, minority health, newborn screening, nutrition, prenatal care, infant mortality, prevention, providers, school health, special health care needs, diseases, chronic conditions, substance abuse (maternal and infants), and treatment services."

King, Mike. Straus, Hal.

In sickness and in health. Atlanta journal and constitution: Sept. 30, 1990: p. 1A, 10A-13A; Oct. 1: p. 1A, 6A-7A; Oct. 2: p. 1A, 8A-9A; Oct. 3: p. 1A, 8A-9A; Oct. 4: p. 1A, 12A-13A.

Five-part series which discusses the cost, access, and quality of health care available in the United States.

Konner, Melvin.

Medicine at the crossroads: the crisis in health care. New York, Pantheon Books, 1993. 296 p.

Korczyk, Sophie M.

Health care needs, resources, and access in rural America; a report to the National Rural Electric Cooperative Association and Prudential Insurance Company of America. Alexandria, Va., Analytical Services, 1989. 66 p.

"Despite efforts at all levels of government to improve rural health care, many rural residents continue to be in poorer health than urban residents, travel farther for care, and are less able to afford it when they find it. Rural areas face the same health care problems as the rest of the nation, compounded by poverty, economic decline, and an aging population. Yet, even as health care costs continue to rise, rural residents are less likely than urban residents to benefit from tax incentives and government spending programs aimed at making care more available and more affordable."

Kosterlitz, Julie.

Dangerous diagnosis. National journal, v. 25, Jan. 16, 1993: 127-130.

Warns the Clinton Administration and Congress that "the public and the experts have expectations of health reform that are vastly different and potentially directly at odds. Everyone says that a dramatic overhaul of the system is needed--but on closer examination, the public strongly resists the kinds of sacrifices that the experts assume will need to be made."

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Radical surgeons. National journal, v. 23, Apr. 27, 1991: 993-997.

"Congress's recognized leaders on health issues face competition from newcomers who are fed up with the failings of the nation's medical system. Some are proposing drastic changes."

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A sick system. National journal, v. 24, Feb. 15, 1992: 376-388.

"After nearly two decades of exploding costs and widespread gaps in insurance coverage, health care has caught fire as a political issue. But the ills of the health system don't lend themselves to quick or simple fixes. Solutions inevitably will entail sacrifices."

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Krebs, Frederick J.
Statement of the U.S. Chamber of Commerce on implications of the Pepper Commission recommendations for the private health insurance market. Washington, The Chamber, 1990. 18 p.

"On March 2, 1990, the Pepper Commission released its recommendations for addressing the problem of growing gaps in coverage. The Chamber views the Pepper Commission's recommendations on access to health care as a mixed bag, and was disappointed by the emphasis on mandated benefits as a solution to the access problem. Despite the best effort of the commission to ameliorate the impact of mandates on small business, the fact remains that mandates will cause job loss and will hurt those they purport to help."

Kronenfeld, Jennie J.
Controversial issues in health care policy. Newbury Park, Calif., Sage Publications, 1993. 186 p. (Controversial issues in public policy)

Levitan, Sar A. Conway, Elizabeth A.
Families in flux: new approaches to meeting workforce challenges for child, elder & health care in the 1990s. Washington, Bureau of National Affairs, 1990. 1 v. (various pagings)
A BNA special report

Local advocacy for the medically indigent. JAMA [Journal of the American Medical Association], v. 263, Jan. 12, 1990: 262-268.

"Access to health care for the medically indigent has emerged as a major policy issue throughout the United States. Because no national health program ensures entitlement to basic services, practitioners and patients must cope with barriers to access on the local level. We report several separate but integrated strategies that a community-based coalition has used to achieve improvements in indigent care within a single county."

Man, Anthony.
Rural health care: closed hospitals only part of problem. Illinois issues, v. 15, May 1989: 12-15.

"As the most visible symptoms of the ailments plaguing rural health in Illinois, hospital closings will continue to get lots of attention--the kind that spurs political and government activity."

Marketing a practical health care policy for the United States. Health marketing quarterly, v. 6, no. 4, 1989: 113-126.

Marquis, M. Susan. Long, Stephen H.
Uninsured children and national health reform. JAMA [Journal of the American Medical Association], v. 268, Dec. 23-30, 1992: 3473-3477.

"In this article, we investigate how alternative incremental approaches to national health care reform affect the number of uninsured children. In limiting our topic, we do not address several important aspects of reform options, including effects on wages and benefits, effects on employment, and who bears the financing burden."

Matlack, Carol.
Staking out turf. National journal, v. 24, Feb. 15, 1992: 390-395.

"The prospect of Congress taking a scalpel to the nation's health care system has sent a shudder through the industry--and kicked K Street [lobbyists] into overdrive. Although nearly everyone agrees that there won't be a major overhaul this year, the jockeying for position is underway."

McNulty, Ruth.
In critical condition. New Jersey reporter, v. 21, Nov.-Dec. 1991: 37-43.

Due to "a health-care system so corroded by deep and enduring structural flaws that a vast--and growing--population of New Jersey residents are routinely denied what most reasonable people would consider a basic human right: access to decent and affordable health care. It is a crisis that crosses socioeconomic lines, engulfing not only the poor and the unemployed but also those who are on the job."

Mechanic, David.
Painful choices: research and essays on health care. New Brunswick, Transaction Publishers, 1989. 248 p.

Medical care and the health of the poor. Cornell University Medical College Eighth Conference on Health Policy. Edited by David E. Rogers and Eli Ginzberg. Boulder, Westview Press, 1993.

Conference held in New York, N.Y. in 1992.

This book should be available later in 1993.

Menzel, Paul T.

Equality, autonomy, and efficiency: what health care system should we have? Journal of medicine and philosophy, v. 17, 1992: 33-57.

"Equitable access does not demand a level and scope of care for the poor equal to that rationally chosen by the middle class, and there are ways within mixed systems, though not easy ways, to achieve a fair distribution of costs between well and ill. Despite pluralistic systems' apparent advantage in allowing subscribers to choose their own forms of rationing, problems in translating serious long-term subscriber choices into actual medical practice may be greater in pluralistic than in unitary systems. Final choice of a system hinges primarily on peculiar historical facts about U.S. political culture, not on moral principle."

The Nation's health. Edited by Philip R. Lee and Carroll L. Estes. 3rd ed. Boston, Jones and Bartlett Publishers, 1990. 448 p. (The Jones and Bartlett series in health sciences)

National Conference on Health Care for the Poor and Underserved (2nd : 1989 : Nashville)

Proceedings of the Second National Conference on Health Care for the Poor and Underserved, Meharry Medical College, Nashville, Tennessee. Journal of health care for the poor and underserved, v. 1, summer 1990: 1-210.

Partial contents.--The Federal initiative, by Louis W. Sullivan.--Health insurance of minorities in the United States.--Recent changes in Medicare and Medicaid.--Current and proposed financing of health care for the poor: second-best solutions, by Eli Ginzberg.--Hospital viability and closures.--Models for increasing access: strengthening community health centers and the National Health Service Corps.--Infant mortality: the shared concern.--Teenage pregnancy prevention.--The aging populace.--Oral health.--AIDS: today's and tomorrow's crisis, by Beny Primm.

National Conference on Health Care for the Poor and Underserved (3rd : 1990 : Nashville)

"Children at Risk": proceedings. Journal of health care for the poor and underserved, v. 2, summer 1991: 1-236.

Conference held Oct. 1-2, 1990, at Meharry Medical College, Nashville, Tenn. [Error in conference date, 1991, in publication].

Partial contents.--The past, present, and future of children at risk, by Antonia C. Novello.--Teenage pregnancy prevention.--Infant morbidity in Harlem.--The Urban child.--The Rural child.--Recognizing and responding to adolescent depression.--Understanding and controlling violence.--Educating homeless children and youth.--Federal efforts to provide for at-risk children, by William A. Robinson.

A National health system for America: critical issues. Edited by Stuart M. Butler and Edmund F. Haislamier. Washington, Heritage Foundation, 1989. 127 p.

Contents.--Why America's health care system is in trouble, by Edmund F. Haislamier.--A framework for reform, by Stuart M. Butler.--Health care for workers and their families, by Edmund F. Haislmaier.--Health care and the elderly, by Peter J. Ferrara.--Health care for the poor, unemployed, and high-risk, by Terree P. Wasley.--The political prospects for reform, by Edmund F. Haislmaier.

National Leadership Coalition for Health Care Reform.

Excellent health care for all Americans at a reasonable cost: a proposal for three-dimensional health care reform. Washington, National Leadership Coalition for Health Care Reform, 1991. 32 p.

"Through a balanced mix of competitive and regulatory strategies, our plan would assure control of skyrocketing costs, universal access to comprehensive health care benefits (including preventive services), major initiatives to improve the quality of care, insurance and malpractice reforms, administrative simplification, reinforcement of professionalism, and a new concept for the delivery of care. It is especially sensitive to the needs of small business."

National Leadership Commission on Health Care (U.S.)
For the health of a nation: a shared responsibility: report of the National Leadership Commission on Health Care. Ann Arbor, Mich., Health Administration Press, 1989. 206 p.

Opinions on health care reform. Business & health, v. 10, Sept. 1992: 18-20-22.
Presents results of several 1992 polls on public opinion about the current health care system and reform options.

Oswald, Nancy.
Access to what? Health care for whom? Health/PAC bulletin, v. 22, spring 1992: 28-31.
"Fundamentally, our current model of health care delivery is expensive and inappropriate for both those who have insurance and those who do not. We need a new model based on preventive and primary health care services."

Pantridge, Margaret.
Future shock. Boston magazine, v. 82, Jan. 1989: 74, 144-149.
"There will be fewer hospitals, and the patients in them will be sicker. Insurance will be more expensive, and it will pay for less. The seeds of the future have already been planted. Here's what you can expect in the nineties."

Public health policy and the Congress. Congressional Research Service review, v. 10, Mar. 1989: 1-28.
Contents.--Public health and politics, by Sarah E. Taylor.--Congress and public health policy, by Sarah E. Taylor.--Public health resources: who cuts the pie? by Edward Klebe.--Biomedical research to improve public health, by Irene Stith-Coleman, and Pamela Smith.--Translating science into public health promotion, by Sarah E. Taylor and Irene Stith-Coleman.--Balancing competing health needs, by Marilyn J. Littlejohn.

Reagan, Michael D.
Curing the crisis: options for America's health care. Boulder, Colo., Westview Press, 1992. 196 p.

Reforming the health care system. Issues in science and technology, v. 7, fall 1990: 6-8, 10-11.
Responents to Edmund F. Haislmaier's article, "A Cure for the Health Care Crisis," include Arnold Relman, Editor of the New England Journal of Medicine; James Todd, American Medical Association officer; Carl Schramm, Health Insurance Association of America president; Bert Seidman; Michael Bromberg; Norman Rosenberg; and Robert Brunton.

Regular source of ambulatory care and access to health services. American journal of public health, v. 81, Apr. 1991: 434-438.
"We conclude that most people who do not have a regular source of ambulatory care report that they do not want one, and the global measure, regular source of ambulatory care, fails to identify those sociodemographic subgroups who are at greater risk of having barriers to obtaining a source of continuity of care. Therefore, if we are truly interested in who is at risk for access barriers to obtaining continuity of care, the reason for lacking a regular source of ambulatory care must be evaluated."

Rhodes, Robert P.
Health care politics, policy, and distributive justice: the ironic triumph. Albany, State University of New York Press, 1992. 339 p. (SUNY series in health care politics and policy)

Rich, Robert F. Arnould, Richard J.
The health care system in Illinois: an emerging crisis needing urgent care. Illinois issues, v. 18, Jan. 18, 1992: 18-23.
"The largest single problem in the health care crisis is the mismatch between people's expectations for health care for all and the realities of what the health care system costs. Illinois as well as the rest of the nation must develop policies that result in the provision of some minimal level of health care services to everyone. The source of payment for that system must be carefully worked out so as to not generate more medically indigent by increasing levels of unemployment. This policy must be implemented with systems of incentives that generate efficient levels of consumption

and production. Finally, we probably cannot avoid implementing some form of formal rationing."

Roberts, Carolyn C.

Roberts: restructuring the system will benefit all. Hospitals, v. 66, Aug. 20, 1992: 26-29.

The chairman-elect designate of the American Hospital Association speaks about restructuring the health care delivery system. "Restructuring the delivery system opens up the possibility of a number of creative solutions for hospitals to design integrated health care delivery systems to meet individual community needs. Along with that decision come numerous policy issues, such as access, quality, cost, tort reform, and ethical considerations, that need to be worked through, but the health care community is very enthusiastic about taking on this challenge."

Rockefeller, Jay.

Health care reform: prospects and progress. Academic medicine, v. 67, Mar. 1992: 141-145.

"For the first time, there is a strong constituency calling for health care reform. The politicians and the health care community must stop ignoring that constituency and instead work together on a health care bill to head off the coming crisis."

The Role of government in health. Health affairs, v. 4, winter 1992: 7-118.

Contents.-- Federal/state partnership for health system reform.--Political evolution of Federal health care regulation.--The Legislative battle over health services research.--AHCPR and the strategy for health care reform.--Role of Federal waivers in the health policy process.--The Courts and health policy: strengths and limitations.--The Influence of the mass media.

Rovner, Julie.

Bush's plan short on details, long on ambition, critics. Congressional Quarterly weekly report, v. 50, Feb. 8, 1992: 305-309.

Gives "highlights and proposals" on the President's Feb. 6 "Comprehensive Health Reform Program," which includes measures to increase access to health care and to contain costs, changes in the insurance market, and proposed financing methods.

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Congress feels the pressure of health-care squeeze. Congressional Quarterly weekly report, v. 49, Feb. 16, 1991: 414-421.

"Everyone agrees that the system is broken, but no one is sure how to fix it."

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Cost of Medicaid puts States in tightening budget vise. Congressional quarterly weekly report, v. 49, May 18, 1991: 1277-1284.

"Yet the more lawmakers and administration officials look to Medicaid as a potential savior for the uninsured, the more problems they find with how it is carrying out its original mission. What began a generation ago as a program to help the nation's poorest people is being overwhelmed by forces that its planners never expected."

Rowland, D. Lyons, B.

Triple jeopardy: rural, poor, and uninsured. Health services research, v. 23, 1989: 975-1004.

Rural health care: innovation in a changing environment. Edited by LaVonne A. Straub and Norman Walzer. Westport, Conn., Praeger, 1992. 218 p.

Rx for America's sick national health care system: what's wrong, the alternative, and how to begin. Christianity and crisis, v. 51, Sept. 23, 1991: 267-295.

"This special issue contains a variety of articles and reviews. Some writers report on successful grassroots efforts to increase health care coverage and access to both information and services. Other writers speak of their concern that reforms based only on access and financing--and not also on fundamental rethinking about what health is and the causes of disease--will in the end prove illusory."

Seidman, Bert.
Curing U.S. health care ills. Washington, National Planning Association, 1991. 90 p.

This report examines "the nation's most important health care problems, the proposals for dealing with them, and the solutions that the NAR [Committee on New American Realities] might consider to help cure the current system's major defects."

Sherman, Deborah J.
The neglected health care needs of street youth. Public health reports, v. 107, July-Aug. 1992: 433-440.

"Street youth were found to have a greater number of problems--both physical and psychological--than the general adolescent population. High-risk behaviors, such as drug abuse and failure to use condoms during sex, make this population especially vulnerable to sexually transmitted diseases, including human immunodeficiency virus. The potential impact on public health is enormous. Adequate access to health services needs to be addressed legislatively."

Shultz, Paul T. Kerns, Robert M.
Current developments in employee benefits. Employee relations law journal, v. 16, summer 1990: 107-114.

"This article takes a closer look at what the [Pepper] Commission proposed, why it failed to build a strong basis for legislation, and where health care policy might be headed from here."

Solovy, Alden.
Health care in the 1990s: forecasts by top analysts. Hospitals, v. 63, July 20, 1989: 34-40, 42, 44, 46.

"Hospitals assembled a team of industry experts--bankers, credit analysts, economists, health care executives, and a futurist--bold enough to provide hard forecasts of 12 key economic and financial indicators . . . . Results of the composite forecast range from the expected--such as health care as a percent of the GNP continuing its rise--to the frightening--such as inflation in the goods and services used by hospitals rising by a compound growth rate of roughly 32 percent through 1995."

Steuerle, C. Eugene.
Beyond paralysis in health policy: a proposal to focus on children. National tax journal, v. 45, Sept. 1992: 357-368.

"The basic elements of the plan are the following: provide a credit or voucher that is sufficient in size to provide a moderate insurance policy for all children in America; require most employers to offer plans that would make use of this voucher; and impose a surcharge (reflected in tax withholding schedules) for those adults who fail to purchase insurance for either their dependent children or themselves.

Strauss, Anselm L. Fagerhaugh, Shizuko. Suczek, Barbara.
AIDS and health care deficiencies. Society, v. 28, July-Aug. 1991: 63-73.

Highlights deficiencies in the American health care system and their impact on the care of AIDS patients. "Areas of deficiency include: 1) home care; 2) difficulties of managing new phases of illness (brought about through increased medical knowledge and improved technology); and 3) inequalities in gaining access to health care."

Sullivan, Joseph M.

Health care reform: toward a healthier society: an address. Hospital & health services administration, v. 37, winter 1992: 519-532.

This revised lecture to the American College of Health Care Executives Congress on Administration by Bishop Sullivan argues that "we have to move beyond the New Federalism, which was a euphemism for returning problem solving to the states without resources . . . . We need structural change [in health care], and this can be brought about only if we opt for compassion and solidarity. The reform we seek ought not only to achieve a high-quality, efficient, and effective health care system, but it ought to be a force for healing society, for making America a just and compassionate nation in which we all become responsible for each other."

Sullivan, Louis W.

The dialogue on health care reform. Labor law journal, v. 42, Oct. 1991: 651-657.

"While many uninsured do not have access to care, a significant percentage of the uninsured do receive care or can afford care if needed. Until the debate moves from its focus on 'the uninsured,' to a focus on the issue of 'access' itself, i.e., real and effective access for the poor and the non-poor, such as those living in urban areas and those in rural areas, we cannot reach consensus on the essential challenge of assuring access to quality care for those who cannot afford it."

Summer, Laura.

Limited access: health care for the rural poor. Washington, Center on Budget and Policy Priorities, 1991. 106 p.

Contents.--Health status of rural and urban residents.--The use of health care services.--The availability of health care providers in rural areas.--Health insurance.--Federal health programs for low income residents in rural areas.--The Medicaid program.

U.S. Commission on the Future Structure of Veterans Health Care.

Proceedings: the price of freedom is visible here. Parts 1-4. Washington, The Commission, 1991. 4 v. (1142, 2152, 2734, 531 p.)

Hearings held June 1990-May 21, 1991, in Washington, Chicago, Boston, Tampa, FL, and Los Angeles.

U.S. Congress. House. Committee on Education and Labor.

Oversight hearing on national health care reform. Hearing, 102nd Congress, 2nd session. May 7, 1992. Washington, G.P.O., 1992. 105 p.

"Serial no. 102-104"

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Labor-Management Relations.

Field hearing on health care access issues. Hearing, 102nd Congress, 1st session. Nov. 2, 1991. Washington, G.P.O., 1992. 124 p.

"Serial no. 102-85"

Hearing held in Great Falls, Mont.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Commerce, Consumer Protection, and Competitiveness.

Access to health insurance. Hearing, 101st Congress, 2nd session, on H.R. 2649 [Federal Health Insurance Equit Act of 1989] ... September 19, 1990. Washington, G.P.O., 1991. 272 p.

"Serial no. 101-212."

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Pepper Commission report (parts 1-2). Joint hearing before the Subcommittee on Commerce, Consumer Protection, and Competitiveness and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, 101st Congress, 2nd session, Apr. 26-June 14, 1990. Washington, G.P.O., 1990. 2 v. (175, 193 p.)

Serial nos. 101-144, 101-182.

Hearing on the recommendations of the Pepper Commission regarding access to health care and implications for the private health insurance system.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Health care reform. Hearings, 102nd Congress, 1st session. Washington, G.P.O., 1992. 374 p.
"Serial no. 102-86"
Hearings held July 10, 1991–The costs of inaction; July 29–Proposals for expanding and financing coverage; Oct. 31–Controlling expenditures.

U.S. Congress. House. Committee on Small Business. Subcommittee on Regulation, Business Opportunities, and Energy.
Health care. Hearing, 102nd Congress, 1st session. Dec. 10, 1991. Washington, G.P.O., 1992. 86 p.
"Serial no. 102-58"

U.S. Congress. House. Committee on the Budget.
Health care cost and access. Hearing, 102nd Congress, 1st session. June 19, 1991. Washington, G.P.O., 1991. 232 p.
"Serial no. 102-17"

U.S. Congress. House. Committee on the Budget. Task Force on Human Resources.
Health care crisis; problems of cost and access. Hearings, 101st Congress, 1st session. Oct. 31 and Nov. 5, 1990. Washington, G.P.O., 1991. 168 p.
"Serial no. 5-13"

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Health care crisis: problems of cost and access. Hearings, 101st Congress, 2nd session. Aug. 23-24, 1990. Washington, G.P.O., 1990. 156 p.
"Serial no. 5-10"
Hearings held in Fresno and Modesto, Calif.

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Health care crisis: problems of cost and access for children of color. Hearing, 101st Congress, 2nd session. Nov. 19, 1990. Washington, G.P.O., 1991. 82 p.
"Serial no. 5-15"

U.S. Congress. House. Committee on Ways and Means.
Health care coverage and costs: major legislative proposals. Washington, G.P.O., 1991. 91 p.
At head of title: 102d Congress, 1st session, committee print, WMCP: 102-21

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President's proposals on health care reform and the fiscal year 1993 Health and Human Services budget. Hearings, 102nd Congress, 2nd session. Washington, G.P.O., 1992. 709 p.
"Serial 102-69"
Hearings held Feb. 20-Mar. 5, 1992.

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Access to health insurance. Hearing, 102nd Congress, 1st session, held in Hartford, Connecticut, February 25, 1991. Washington, G.P.O., 1991. iv, 159 p.
"Serial no. 102-6."

U.S. Congress. House. Select Committee on Aging.
Building an American health system: journey toward a healthy and caring America. Hearing, 101st Congress, 1st session. Nov. 9, 1989. Washington, G.P.O., 1990. 199 p.
"Comm. pub. no. 101-759"

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Building an American health system: journey toward a healthy and caring America. Report, 101st Congress, 2nd session. Washington, G.P.O., 1990. 21 p.
At head of title: Committee print.
"Comm. pub. no. 101-740"

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Hispanic health care: today's shame, tomorrow's crisis: joint hearing before the Select Committee on Aging and the Congressional Hispanic Caucus, 102d Congress, 1st session, September 19, 1991. Washington, for sale by the Supt. of Docs., G.P.O., 1992. 275 p.

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The need for U.S. health reform: uninsured and chronically ill Americans. Joint hearing before the Select Committee on Aging and the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 102nd Congress, 2nd session. Feb. 6, 1992. Washington, G.P.O., 1992. 169 p.
"Aging comm. pub. no. 102-865"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
The nation's health care crisis. Hearing, 102nd Congress, 1st session. Oct. 25, 1991. Washington, G.P.O., 1992. 91 p.
"Comm. pub. no. 102-838"
Hearing held in Middleburg Heights, Ohio.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
Health care for all generations. 102nd Congress, 2nd session. Washington, G.P.O., 1992. 109 p.
At head of title: Committee print.
"Comm. pub. no.102-860"
Briefing held Jan. 25, 1992, in Chattanooga, TN, was "printed for informational purposes only. It does not represent either findings or recommendations adopted by this Committee."

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
America's growing crisis: access to affordable health care. Hearing, 102nd Congress, 2nd session. Sept. 4, 1992. Washington, G.P.O., 1993. 137 p.
Hearing held in Vineland, N.J.
"Comm. pub. no. 102-895"

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The crisis in rural health care: problems of access, affordability and quality. Hearing, 102nd Congress, 1st session. Aug. 16, 1991. Washington, G.P.O., 1991. 252 p.
"Comm. pub. no. 102-827"
Hearing held in Boise, Idaho.

U.S. Congress. House. Select Committee on Aging. Task Force on the Rural Elderly.
Health care in rural America: the pressing need for reform. Hearing, 102nd Congress, 1st session. Sept. 4, 1991. Washington, G.P.O., 1991. 243 p.
"Comm. pub. no. 102-832."
Hearing held in Edgefield, S.C.

U.S. Congress. House. Select Committee on Children, Youth, and Families.
The changing face of health care: the movement toward universal access. Hearing, 101st Congress, 1st session, Dec. 11, 1989. Washington, G.P.O., 1990. 201 p.
Hearing held in New Haven, CT.

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Health care reform: how do women, children, and teens fare? Hearing, 102nd Congress, 2nd session. May 5, 1992. Washington, G.P.O., 1992. 227 p.

U.S. Congress. Joint Economic Committee. Subcommittee on Education and Health.
The future of health care in America. Hearings, 100th Congress, 2nd session. Parts 1-2. Washington, G.P.O., 1989. 2 v. (Hearings, 100th Congress, 2nd session, S. Hrg. 100-1038, pts. 1-2)
Hearings held May 3-June 23, 1988.

U.S. Congress. Senate. Committee on Finance.
Better access to affordable health care. Hearing, 102nd Congress, 2nd session on S. 1872 [Better Access to Affordable Health Care Act of 1991]. Feb. 20, 1992. Washington, G.P.O., 1992. 206 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-712)

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Health care costs and lack of access to health insurance. Hearing, 102nd Congress, 1st session. Parts 1-2. Apr. 9-June 6, 1991. Washington, G.P.O., 1991. 2 v. (268, 132 p.) (Hearing, Senate, 102nd Congress, 1st session, S. Hrg. 102-84, pts. 1-2)

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Rural health care crisis. Hearings, 101st Congress, 2nd session. June 2, 1990. Washington, G.P.O., 1990. 135 p. (Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-1149)

Hearings held in Sioux Falls and Rapid City, SD.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health for Families and the Uninsured.
Comprehensive reform of the health care system. Hearings, 102nd Congress, 1st session on S. 1227 [HealthAmerica: Affordable Health Care for All Americans Act] and S. 1669 [Improvements to the HealthAmerica Act of 1991]. Sept. 23-30, 1991. Washington, G.P.O., 1992. 218 p. (Hearings, Senate, 102nd Congress, 1st session, S. Hrg. 102-462)

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Effect of health care costs on the economy. Hearing, 102nd Congress, 2nd session. May 18, 1992. Washington, G.P.O., 1992. 73 p.

"The hearing today will explore the problems that employers are facing with high health care costs and the impact that that is having on American workers and consumers, and also the ability of our companies and our workers to compete effectively, both here in the United States and overseas."

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HealthAmerica: affordable health care for all Americans. Hearing, 102nd Congress, 1st session on S. 1227. Sept. 6, 1991. Washington, G.P.O., 1992. 182 p. (Hearing, Senate, 102nd Congress, 1st session, S. Hrg. 102-427)

Hearing held in East Lansing, Mich.

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Health care for the uninsured. Hearing, 101st Congress, 1st and 2nd sessions. June 19, 1989-Apr. 18, 1990. Washington, G.P.O., 1990. 2 v. (1126, 308 p.) (Hearing, Senate, 101st Congress, 1st and 2nd sessions, S. Hrg. 101-566, pts. 1-2)

Hearings held in Washington, D.C., Southfield, MI, and Warren, Mich.

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Reform of the health care system. Hearing, 102nd Congress, 1st session. Feb. 25, 1991. Washington, G.P.O., 1991. 139 p. (Hearing, Senate, 102nd Congress, 1st session, S. Hrg. 102-168)

Includes GAO factsheet, "A Profile of the uninsured; GAO/HRD-91-31FS, B-241536."

U.S. Congress. Senate. Committee on Finance. Subcommittee on Medicare and Long-Term Care.
Rural health care. Hearing, 101st Congress, 1st session. May 19, 1989. Washington, for sale by the Supt. of Docs., G.P.O., 1990. 102 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg., 101-490.)

U.S. Congress. Senate. Committee on Labor and Human Resources.
The American health care crisis: a view from four communities. Hearing, 101st Congress, 1st session. Washington, G.P.O., 1990. 234 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-522)

Hearings held Dec. 11, 1989, Bronx, N.Y.; Dec. 12, 1989, Los Angeles, CA; Dec. 13, 1989, Maplewood, MO; Dec. 14, 1989, Sparta, GA.

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Comprehensive health reform: HealthAmerica and the administration proposal. Hearing, 102nd Congress, 2nd session. Mar. 4, 1992. Washington, G.P.O., 1992. 112 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-815)

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The health care crisis: a report to the American people. Washington, G.P.O., 1990. 78 p. (Print, Senate, 101st Congress, 2nd session, committee print, S. Prt. 101-100)

Partial contents.--The uninsured and underinsured.--Long-term care.--Rising cost of health care.--Failing financial condition of health institutions.--Drugs and AIDS.--The crisis in New York City: the twin epidemics of AIDS and drugs add to the strain of an overburdened system.--Los Angeles.--The crisis in St. Louis.--Sparta, Georgia: the health care crisis in rural America.

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The health care crisis and the American family. Hearing, 102nd Congress, 1st session. Jan. 10, 1991. Washington, G.P.O., 1991. 122 p. (Hearing, Senate, 102nd Congress, 1st session, S. Hrg. 102-38)

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Pepper Commission recommendations on universal health care. Hearing, 101st Congress, 2nd session. Apr. 6, 1990. Washington, G.P.O., 1990. 182 p. ( Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-959)

U.S. Congress. Senate. Committee on the Budget.
Crisis in rural health care. Hearing, 101st Congress, 1st session. Feb. 13-16, 1989. Washington, G.P.O., 1990. 452 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-480)

Hearings held in Fargo, Grand Forks, and Minot, ND.

U.S. Congress. Senate. Pepper Commission.
Access to health and long-term care. Hearing, 101st Congress, 1st session. Part 1. May 25, 1989. Washington, G.P.O., 1990. 197 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-968)

Hearing held in St. Louis Park, Minn.

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Business, labor, and consumers: views on health care and long-term care. Hearing, 101st Congress, 1st session. Part 3. July 5, 1989. Washington, G.P.O., 1990. 85 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-978)

Hearing held in Cincinnati, Ohio.

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A call for action: supplement to the final report. Washington, G.P.O., 1990. 241 p. (Print, Senate, S. Prt. 101-115)

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Health care in rural America: the frontier perspective. Hearing, 101st Congress, 1st session. Part 2. June 28, 1989. Washington, G.P.O., 1990. 211 p. (Hearing, Senate, 101st Congress, 1st session, S.Hrg. 101-969)

Hearing held in Missoula, Mont.

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The insurance industry and access to health care and long-term care. Hearing, 101st Congress, 1st session. Aug. 21, 1989. Washington, G.P.O., 1990. 76 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-988)

Hearing held in Des Moines, IA.

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Long-term care and access to health care: examining the scope of the problems. Hearing, 101st Congress, 1st session. Part 7. Sept. 21, 1989. Washington, G.P.O., 1990. 209 p.

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Options in access to health care. Hearing, 101st Congress, 1st session. Part 9. Oct. 24, 1989. Washington, G.P.O., 1990. 777 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-700)

—— Recommendations to the Congress by the Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, 101st Congress, 2nd session, on access to health care and long-term care for all Americans. Mar. 2, 1990. Washington, G.P.O., 1990. 21 p.

The Pepper Commission proposal assures health care coverage for all Americans through a job-based/public system . . . [and] provides all Americans coverage for home and community-based long-term care services and protection against impoverishment in nursing homes."

—— Small business health care problems and long-term care. Hearing, 101st Congress, 1st session. Part 4. July 6, 1989. Washington, G.P.O., 1990. 398 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-982)

U.S. Congress. Senate. Special Committee on Aging.

Access to care for the elderly. Hearing, 101st Congress, 1st session. Aug. 7, 1989. Washington, G.P.O., 1990. 63 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-680)

"Serial no. 101-7"

Hearing held in Aberdeen, SD.

—— Improving access to primary health care. Hearing, 101st Congress, 2nd session. Aug. 28, 1990. Washington, G.P.O., 1990. 151 p. (Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-1272)

Hearing held in Albuquerque, N. Mex.

"Serial no. 101-28"

U.S. General Accounting Office.

Access to health care: States respond to growing crisis; report to congressional requesters. June 16, 1992. Washington, G.A.O., 1992. 82 p.

"GAO/HRD-92-70, B-245950"

"Describes comprehensive plans to provide universal access to coverage, programs to extend access to specific groups, and efforts to control costs by reforming payment mechanisms."

—— Health care: limited State efforts to assure quality of care outside hospitals; report to the chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. Jan. 30, 1990. Washington, G.A.O., 1990. 65 p.

"GAO/HRD-90-53, B-236203"

Offers information on "State quality assurance activities concerning (1) licensing, inspection, and enforcement for 16 types of freestanding providers and (2) inspection and enforcement activities for health maintenance organizations."

—— Quality assurance: a comprehensive, national strategy for health care is needed; briefing report to the chairman, United States Bipartisan Commission on Comprehensive Health Care. Feb. 21, 1990. Washington, G.A.O., 1990. 32 p.

"GAO/PEMD-90-14BR, B-237200"

Delineates "four elements as essential to a comprehensive national strategy: (1) national practice guidelines and standards of care; (2) enhanced data to support quality assurance activities; (3) improved approaches to quality assessment and assurance at the local level; and (4) a national focus for developing, implementing, and monitoring a national system."

—— VA health care: medical centers are not correcting identified quality assurance problems; report to the Chairman, Committee on Veterans' Affairs, U.S. Senate. Dec. 30, 1992. Washington, G.A.O., 1992. 39 p.

"GAO/HRD-93-20, B-251725"

Warns about continuing problems in reporting and investigating patient incidents and documenting the supervision of resident physicians. Recommends both targeting known problem areas and visitation by regional office inspection teams to insure that quality assurance programs are being implemented and that problems are being corrected.

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VA health care: use of private providers should be better controlled; report to the Chairman, Committee on Veterans' Affairs, U.S. Senate. Sept. 28, 1992. Washington, G.A.O., 1992. 23 p.

"GAO/HRD-92-109, B-249947"

"VA did not provide adequate guidance to medical centers on how to evaluate the cost-effectiveness of private care in deciding whether to authorize private care at VA expense, nor did it adequately monitor centers' use of private care authorizations .... Requiring authorizations for private care to be based on economic considerations is required by law and VA policy."

U.S. President (1989-1993 : Bush)

The President's comprehensive health reform program. Washington, G.P.O., 1992. 94 p.

President's plan: "guarantees access to health insurance for all poor families; provides insurance security for all poor families; provides insurance security for all Americans; will reduce the cost of health insurance through major market reforms; provides new help to the middle class to pay for health care; encourages growth of coordinated care; inlcudes major malpractice reform and would expand services in undeserved areas."

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Proposed legislation--Health Care Liability Reform and Quality of Care Improvement Act of 1991; message. Washington, G.P.O., 1991. 46 p. ( Document, House, 102nd Congress, 1st session, no. 102-84)

"A draft of proposed legislation to improve health care delivery system and ensure access to affordable quality health care through reduced liability costs and improved quality of care, and for other purposes .... Message and accompanying papers referred to the Committees on the Judiciary, Energy and Commerce, and Ways and Means."

U.S. Public Health Service. National Vaccine Program Office. Interagency Committee on Immunization.

Action plan to improve access to immunization services; report. Washington, The Committee, 1992. 42 p.

Focuses on services "for pre-school age children and targeting to high-risk and hard to reach populations. To accomplish this, the Plan emphasizes improving access to immunization services through improved coordination among Federal health, income, housing, education, and nutrition programs." Sets out responsibilities of the Administration for Children and Families, Centers for Disease Control, Health Care Financing Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, National Vaccine Program Office, Office of the Surgeon General, Office of Minority Health, Dept. of Housing and Urban Development, Dept. of Agriculture, and Dept. of Education."

Victor, Kirk.

Gut issue. National journal, v. 22, Mar. 24, 1990: 704-707.

"Health care coverage and costs--which used to be minor items in the rough and tumble of collective bargaining--have rapidly become central impediments to contract settlements. Disputes over health benefits were a prime factor in 78 per cent of major strikes involving 1,000 or more workers in 1989--up from 18 per cent only three years earlier, according to a study by the Service Employees International Union (SEIU)."

Wagner, Judith L.

The competitive solution and the health care problems of today. Quarterly review of economics and business, v. 30, winter 1990: 95-100.

"This article examines how well the competitive solution deals with the five central problems of the health care system: (1) almost universal lack of adequate health insurance for nursing homes and home care; (2) Medicaid's penurious approach to payment for health services for the poor; (3) the emergence of a dual health care system, especially for children; (4) the entrenched waste and inefficiency of the health care system; and (5) consumers' inability to judge the quality of health care. The competitive solution does not eliminate any of these problems--and may not even improve some of them."

Wasley, Terree P.
What has government done to our health care? Washington, Cato Institute, 1992.
This book will be available later in 1993.

Watson, Sidney D.
Reinvigorating title VI: defending health care discrimination--it shouldn't be so easy. Fordham law review, v. 58, Apr. 1990: 939-970.
"The American health care system as it presently operates is not meeting the needs of America's minority population. A deferential standard of justification allows health care business to continue as usual, but business as usual has not made health care accessible to America's minorities. A burden of justification that focuses on less discriminatory alternatives will encourage the development of new approaches to health care administration that will help bring minority patients into federally funded health care programs."

Weisbrod, Burton A.
The Health care quadrilemma: an essay on technological change, insurance, quality of care, and cost containment. Journal of economic literature, v. 29, June 1991: 523-552.
Posits a "dynamic interplay of incentives for the R & D sector to develop particular kinds of new technologies, the role of the insurance system in that process, and reciprocally, the long-run effects of new technologies (any new knowledge about health care) on the character of the health care insurance system."

What's ahead in health care? Business & health, v. 10, Dec. 1992: 32-34, 36-40, 42.
Contents.--What's ahead in health care for 1993?, by Norma Harris.--Employers plan more aggressive cost-cutting strategies, benefits survey show, by Norma Harris.--Health care group aims at community-based systems, by Steven Findlay.

Whither health care reform? A roundtable. Issues in science and technology, v. 9, fall 1992: 55-64.
John Immerwahr, Walter B. Maher, Theodore R. Marmor, and Robert E. Moffit discuss the roles, responsibilities, and risks of American employers in health care reform.

Why conservatives don't talk about America's health system. Washington, Democratic Study Group, 1991. 66 p. (DSG special report no. 102-6)
Contents.--A terminally ill health system.--Cost & quality: how the United States compares with other nations.--Why are U.S. costs so much higher?

Wiener, Joshua M. Engel, Jeannie.
Improving access to health services for children and pregnant women. Washington, Brookings Institution, 1991. 90 p. (Brookings dialogues on public policy)

Wiener, Joshua M. Hanley, Raymond J.
Winners and losers. Brookings review, v. 10, fall 1992: 46-49.
"The present system of health care in the United States, with its explosive increases in costs and growing numbers of uninsured, is both unfair and financially unsupportable over the long run. As a result, policymakers will be looking increasingly at the option of rationing and the decisions it requires about the allocation of resources between low-technology primary care and high-technology specialty care. On balance, virtually all rationing schemes would make primary care more accessible than it is now. But the key question is: how much will improvements in access to primary care be at the expense of high-technology services?"

Winners and losers in reforming the U.S. health care system. Washington, Employee Benefit Research Institute, 1991. 43 p. (EBRI special report, SR-11)
"Selected papers and discussion from the October 1990 EBRI-ERF Policy Forum."
Partial contents.--The will to change, by Selwyn Feinstein.--Winners and losers in reforming the U.S. health care system, by Stephen Long.--Health care reform: a review of five generic proposals, by Michael A. Morrisey.

Wolfe, Sidney.
Sidney Wolfe: the Progressive interview. Progressive, v. 57, Mar. 1993: 32-34.
"Somebody has to look out for people who are being manipulated by the hospitals, doctors, insurance and drug companies," says Wolfe, the hematology biochemist who founded the Public Citizen Health Research Group. Wolfe discusses the health care system and current public health problems in an interview with Robert Spero.

Yee, Donna L.

Health care access and advocacy for immigrant and other underserved elders. Journal of health care for the poor and underserved, v. 2, spring 1992: 448-464.

"Little is known about health access and advocacy for elders of color, and even less is known about immigrant elders, whose growing number is the major reasons that almost one of every three older persons in the U.S. by the year 2005 will be an elder of color. This paper explores a number of access barriers faced by underserved elders, including inequitable long-term care services and counterproductive 'colorblind' approaches to caregiving."

## II. RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE COMPREHENSIVE NATIONAL HEALTH INSURANCE TO ALL UNITED STATES CITIZENS

### A. GENERAL

Anzick, Michael.
The Medicare program and its role in the U.S. health care system. Washington, Employee Benefit Research Institute, 1991. 16 p. (EBRI issue brief, no. 115)
Medicare "is the largest single purchaser of health care services in the United States." Predicts "a politically volatile situation" to emerge from expectations of individuals who retire and changes occurring in health benefits.

Biemesderfer, Susan C.
Running for coverage. State legislatures, v. 18, July 1992: 54, 57-59.
"The health care crunch has been newly billed by economists as part of the 'middle class squeeze,' making it a campaign issue among the voting middle class and the 'working poor,' and consequently giving a political voice to uninsured Americans."

Blumenthal, David. Rizzo, John A.
Who cares for uninsured persons? Medical care, v. 29, June 1991: 502-520.
"Physician involvement with uninsured patients is a topic of increasing policy interest. In the past, data limitations have hindered analysis of factors influencing physician contact with uninsured patients. This article attempts to bridge this gap in the health services research literature. Using a nationally representative sample of nonfederal patient care physicians, the study revealed marked variations in physician involvement with uninsured patients by specialty class, employment status, and other practice characteristics."

Brook, Robert H.
Health, health insurance, and the uninsured. JAMA [Journal of the American Medical Association], v. 265, June 12, 1991: 2998-3002.
"The purpose of this article is to express a personal viewpoint that might be useful in designing policies to improve the health of the American population. Emphasis will be placed on the uninsured."

Brown, E. R.
Access to health insurance in the United States. Medical care review, v. 46, 1989: 349-385.

Brown, Lawrence D.
The medically uninsured: problems, policies, and politics. Journal of health politics, policy and law, v. 15, summer 1990: 413-426.
"The ranks of the medically uninsured have grown significantly in recent years, but no consensus on a policy solution has emerged. After summarizing the characteristics of the uninsured population, this paper reviews diverse policy responses and their troubled political prospects."

Comer, John. Mueller, Keith.
Correlates of health insurance coverage: evidence from the Midwest. Journal of health care for the poor and underserved, v. 3, fall 1992: 305-320.
"The Midwest is often overlooked in national studies of health insurance status. We analyzed the economic and social characteristics of uninsured and underinsured individuals and households in a Midwestern state using both bivariate and multivariate techniques. As in much of the country, economic factors, particularly income and unemployment, were most significant in accounting for insurance coverage. Unexpectedly, rural and urban residents were equally likely to lack insurance. Results indicate that in rural areas, underinsurance may be a greater problem than uninsurance, and that income-based health insurance is more effective than employer-provided plans in reaching all Americans."

Custer, William S.
Health insurance coverage for the near elderly. Washington, Employee Benefit Research Institute, 1990. 54 p.

"This research seeks to determine how individuals between the ages of 55 and 64, the near elderly, differ from people in younger cohorts, what is their source for health insurance, what are the characteristics of the near elderly without health insurance, and how have these factors changed over time."

Does health insurance make a difference? Background paper. Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1992. 80 p.
"OTA-BP-H-99"

"Provides interim results of OTA's assessment 'Technology, Insurance, and the Health Care System.' It reviews the scientific literature linking health insurance status with access to and the use of health services, and with individual outcomes."

Foley, Jill.
Sources of health insurance and characteristics of the uninsured: analysis of the March 1992 Current Population Survey. Washington, Employee Benefit Research Institute, 1993. 70 p. (EBRI issue brief no. 133, Jan. 1993 EBRI special report)

Provides detailed statistics "that will prove useful in evaluating and estimating costs of health care reform proposals." Most tables cover the nonelderly, whose most common source is private health insurance.

Friedman, Emily.
The uninsured: from dilemma to crisis. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2491-3495.

"The uninsured, however, like the proverbial poor, seem always to be with us. In fact, their numbers have grown significantly in the past 15 years. Proposals for solutions are rife, but consensus on how to attack the problem has proven, to say the least, elusive. Nevertheless, the dilemma of the uninsured has become a crisis, affecting all aspects of the health care system and many aspects of society."

Friedman, Joyce.
Genetic testing: what will it mean for health insurance? Business & health, v. 9, Mar. 1991: 40, 42, 44, 46.

"With the benefits of genetic testing also comes controversy over what should be done with the information gained from the tests. One of the hottest areas of controversy is the role of genetic testing in medical insurance underwriting. What happens when genetic testing results are used to deny patients medical insurance--or greatly raise their premiums?"

Ginzberg, Eli. Ostow, Miriam.
Beyond universal health insurance to effective health care. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2559-2562.

"Faced with insurmountable obstacles to the early establishment of universal health care coverage, the United States should use the next years to experiment with removing discrete barriers that currently impair the access of many millions of Americans to proper medical care. Such experimentation should contribute to designing a more effective system of universal coverage, if and when the opportunity arises."

Health care reform: prescriptions for change. National voter, v. 42, Sept.-Oct. 1992: 7-18.

Contents.--Prescriptions for change.--Health care position statement, by the League of Women Voters.--To play or not to play: that is the question businesses would face under employer-based reforms.--HealthAmerica: a viable solution, by Sen. George J. Mitchell.--National health insurance: debating the single-payer solution.--The American Health Security Plan, by Sen. Harris Wofford.--Can health care go to market?--A consumer-choice health plan for America.

Hillgren, Sonja. Henderson, Pam.
High-stakes health insurance. Farm journal, v. 114, Sept. 1990: 15-18.

"Health care is the No. 1 problem for rural Americans today. Forget commodity programs and trade. They may be problems, but they're not as big," says Aaron Trippler, of Communicating for Agriculture, a nonprofit Minnesota organization that sells health insurance to 80,000 farmers nationwide and leads insurance-reform efforts."

Hubbard, R. Glenn.
The President's 1992 health care white paper: an economic perspective. National tax journal, v. 45, Sept. 1992: 347-356.

"The President's White Paper addressed problems of access and cost containment in health insurance, with proposals for significant changes in current health insurance arrangements. Its success, if adopted, will likely depend on how well it can adapt to the concerns raised in these observations.

Kass, Nancy E.
Insurance for the insurers: the use of genetic tests. Hastings Center report, v. 22, Nov.-Dec. 1992: 6-11.

"Genetic testing raises concerns that individuals will be denied health insurance (and thus, effectively, access to health care), or that employers will screen to eliminate potentially costly workers. Although we as a society do not yet concur on the degree to which private businesses have a responsibility to promote social justice, several different policy alternatives might allow us to weigh the interests of insurers, as businesses, against the interests of citizens in a responsible manner."

Knowles, Robert G.
"Restore choice in health system." National underwriter (life/health/financial services), v. 94, July 9, 1990: 3, 17.

Kronick, Richard.
Health insurance, 1979-1989: the frayed connection between employment and insurance. Inquiry (San Francisco), v. 28, winter 1991: 318-332.

"The paper explores two types of explanations for the decline in coverage among low-income workers. First, the decline might have resulted from increases in the price of medical care, the cost of administering health insurance, and from a breakdown in the small group insurance market. Second, the decline might have resulted from changes in the structure of the economy that changed the types of jobs available to low-income workers. Since coverage declines among the self-employed parallel coverage declines among the employed, it seems likely that increases in the price of health insurance are a larger part of the cause for coverage declines than are changes in the structure of the economy, but further research on this question is needed."

Levy, Margaret.
Current coverage issues in health insurance law: is there coverage when there is no coverage? Tort & insurance law journal, v. 26, spring 1991: 621-636.

"The current coverage issues which arise repeatedly in the health insurance area tend to have one thing in common--insureds or former insureds are seeking to obtain or extend coverage under health insurance policies where no such coverages exists. A prime example of such an issue occurs in connection with the termination or modification of group health insurance policies. Although healthy insured are able to obtain other coverage, insureds who are already seriously ill, injured or disabled at the time of termination or modification are often unable to obtain new health insurance coverage. Accordingly, they argue that they have a vested right to benefits for any illness that commenced or injury that occurred while the policy was in force or before it was modified."

Long, Stephen H. Marquis, M. Susan.
Gaps in employer coverage: lack of supply or lack of demand? Health affairs, special supplement 1993: 282-293.

"The question explored here is whether the absence of insurance in these firms is related to lack of supply (that is, a failure of the firm to offer the benefit because the price it faces is too high or the benefit too low) or lack of demand (that is, employees in these firms would not purchase the insurance even if it were offered)."

Marmor, Theodore R. Boyum, David.
American medical care reform: are we doomed to fail? Daedlus, v. 121, fall 1992: 175-194.

"Marmor encourages the pursuit of a single-payer plan modelled on the Canadian system. Boyum, in contrast, supports a form of managed competition, one that would completely sever the traditional linkage of insurance and employment, putting all citizens--whether employed, unemployed, or self-employed--on equal footing. But despite this, the authors agree more than disagree: on the diagnosis of the problems, on the necessity of systemic rather than incremental reform, and on the crucial importance of implementation."

Morrissey, Joanne S.
Fair coverage for all. Best's review: life/health/insurance edition, v. 93, Nov. 1992: 57-58, 110.

"To provide equal access to health care for all individuals, America needs a workable structure that involves everyone: the government, individuals, businesses and insurers. A willingness on the part of the American people to accept responsibility for themselves also plays a part. But a feasible system must start with a commitment by each sector to a realistic plan."

Murray, Thomas H.
Genetics and the moral mission of health insurance. Hastings Center report, v. 22, Nov.-Dec. 1992: 12-17.

"Deciding whether genetic differences among individuals are morally relevant to health insurance requires us to ask, What kind of good is health care? and, What principles should govern its distribution? There are good reasons to doubt that 'actuarial fairness' is an adequate description of genuine fairness in health insurance."

Parham, Linda.
Pepper Commission tackles health insurance scarcity. Pension world, v. 26, Oct. 1990: 32, 35-36.

"Today's scarcity of affordable insurance for small business owners in combination with benefit cutbacks from larger employers fighting to contain soaring health care costs could endanger covered workers."

Proctor, Rosemary.
Health policy diagnosis. Policy options, v. 12, Oct. 1991: 3-12.

Contents.--The bitter debate over health policy, by Rosemary Proctor.--A word of advice to Americans: don't copy Canada's health care system, by Douglas J. McCready.--Doing the right things, by Kenneth J. Fyke and Barbara Poole.

Swartz, Katherine. McBride, Timothy D.
Spells without health insurance: distributions of durations and their link to point-in-time estimates of the uninsured. Inquiry, v. 27, fall 1990: 281-288.

"Half of all uninsured spells end within 4 months while only 15% last longer than 24 months . . . . Efforts to increase health insurance coverage via employer mandates should proceed cautiously until we know how many people with long uninsured spells are employed."

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Labor-Management Relations.
Oversight hearing on small business health insurance problems. Hearing, 102nd Congress, 2nd session, Washington, DC, April 30, 1992. Washington, For sale by the Supt. of Docs., Congressional Sales Office, G.P.O., 1992. 133 p.

"Serial no. 102-110."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Health insurance coverage and reform. Hearing, 101st Congress, 1st session. Mar. 9, 1989. Washington, G.P.O., 1989. 137 p.

"Serial no. 101-18"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Access to health insurance. Hearing, 102nd Congress, 1st session. Feb. 25, 1991. Washington, G.P.O., 1991. 159 p.

"Serial 102-6"

Hearing held in Hartford.

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Health insurance and the uninsured. Hearing, 101st Congress, 1st session. Apr. 6, 1989. Washington, G.P.O., 1989. 124 p.

"Serial 101-24"

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Health insurance for children and pregnant women. Hearing, 101st Congress, 2nd session. Mar. 20, 1990. Washington, G.P.O., 1990. 102 p.

"Serial 101-78"

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Health insurance for the unemployed. Hearing, 102nd Congress, 1st session. Mar. 21, 1991. Washington, G.P.O., 1991. 106 p.
"Serial 102-12"

U.S. Congress. House. Select Committee on Aging.
In poor health: the Federal commitment to vulnerable Americans. Hearing, 101st Congress, 2nd session. Mar. 5, 1990. Washington, G.P.O., 1990. 124 p.
"Comm. pub. no. 101-785"

U.S. Congress. Senate. Committee on Finance.
Health care coverage for children. Hearing, 101st Congress, 1st session. June 20, 1989. Washington, G.P.O., 1990. 242 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-668)

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Lack of health insurance coverage in the United States. Hearing, 100th Congress, 2nd session. June 30-July 25, 1988. Washington, G.P.O., 1989. 2 v. (172, 167 p.) (Hearing, Senate, 100th Congress, 2nd session, S. Hrg. 100-758, pts. 1-2)

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health for Families and the Uninsured.
Uncompensated health care costs for the uninsured. Hearing, 101st Congress, 2nd session. July 23, 1990. Washington, G.P.O., 1991. 106 p. (Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-1222)

U.S. Congress. Senate. Committee on Labor and Human Resources.
Health care crisis: human impact on insurance company abuse. Hearing, 102nd Congress, 2nd session. June 24, 1992. Washington, G.P.O., 1992. 44 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-830)

U.S. General Accounting Office.
Health insurance: a profile of the uninsured in Michigan and the United States: report to the chairman, Subcommittee on Health for Families and the Uninsured, Committee on Finance, U.S. Senate. May 31, 1990. Washington, G.A.O., 1990. 21 p.
"GAO/HRD-90-97, B-239251"
Michigan had over 860,000 uninsured individuals under age 65, down from a 1984 peak of over 1 million persons. "A high percentage of uninsured people were among the lower income, minority, youth, and unmarried segments of the population. Most uninsured people in Michigan live in families with an employed worker, and mirrored characteristics of those embodied in the national uninsured population."

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Health insurance: an overview of the working uninsured; report to the chairman, Committee on Finance, U.S. Senate. Feb. 24, 1989. Washington, G.A.O., 1989. 54 p.
"GAO/HRD-89-45, B-230452"
Discusses "the characteristics of the working uninsured, the kinds of employers that do not offer health insurance, and the reasons these employers give for not providing it . . . . Discusses where the uninsured obtain medical care, the types of bills they incur, and who pays those bills . . . . Outlines the policy options available for providing health insurance to the working uninsured."

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Health insurance coverage: a profile of the uninsured in selected States; fact sheet for the Chairman, Subcommittee on Health for Families and the Uninsured. Feb. 8, 1991. Washington, G.A.O., 1991. 58 p.
"GAO/HRD-91-31FS, B-241836"
Uses data from the Bureau of Census' March 1989 Current Population Survey to analyze characteristics of the medically uninsured in Alabama, California, Florida, Georgia, Illinois, Louisiana, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Virginia.

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Hispanic access to health care: significant gaps exist; report to congressional requesters. Jan. 15, 1992. Washington, G.A.O., 1992. 30 p.

"GAO/PEMD-92-6, B-245673"

"For many Americans, the first step in accessing health care is the acquisition of health insurance. Hispanics, however, are much less likely than others to have health insurance coverage. Thirty-three percent of all Hispanics were without health insurance in 1989, and this problem was especially acute for the Mexican-American community, where 37 percent were uninsured."

Universal health insurance. Health/PAC bulletin, v. 20, summer 1990: 3-33.

Contents.--The debate is in the States, by Dana Hughes and Zoe Clayson.--California dreaming, by Kevin Grumbach.--Campaigning for health care reform, by Davd West.--The universal health care law in action, by Rob Restuccia.--Patchwork not Perestroika, by David U. Himmelstein, and Steffie Woolhandler.--Importing health care reform? by Samuel Wolfe.

Valdez, R. Burciaga.
Insuring Latinos against the costs of illness. Santa Monica, Calif., Rand Corporation, 1991. 7 p. (Rand paper P-7750)

Testimony before Select Committee on Aging and the Congressional Hispanic Caucus in which he states: "Numerous recent publications reveal that many Latinos, especially Mexican Americans, have the lowest level of medical and mental health care utilization in the country. While it is not completely clear why this situation exists, issues of access to care are at the center of the debate. Health insurance coverage and affordability are major determinants of access to care."

Zoler, Mitchell.
Genetic tests: can we afford the answers? Medical world news, v. 32, Jan. 1991: 32-37.

"Doctors may see many patients develop gaps in health insurance as today's occasional exclusions for genetically diagnosed risk proliferate. Gene researchers already fear misuse of their advances. As they produce ways to predict major illnesses, coverage cuts could evoke national insurance."

## B. NATIONAL HEALTH INSURANCE

### 1. Federal Government as Payor

Bandow, Doug.
Is nationalized health care the right prescription? Business and society review, no. 79, fall 1991: 29-33.

"The answer is neither a huge new federal program nor a federal takeover of the medical system. Instead, the solution is to make the current health care industry more efficient by forcing providers to face competition and consumers to be more cost conscious."

Battin, Margaret P.
Dying in 559 beds: efficiency, 'best buys', and the ethics of standardization in national health care. Journal of medicine and philosophy, v. 17, 1992: 59-77.

"While a national health care system may be greeted with enthusiasm on many grounds, it poses substantial moral problems--not the least of which would be the clash between the 'standardization' of care for the sake of efficiency and the needs of individual patients. Such problems are best seen in the treatment of dying patients."

Battistella, Roger M. Weil, Thomas P.
National health insurance reconsidered: dilemmas and opportunities. Hospital & health services administration, v. 34, summer 1989: 139-165.

"The authors conclude that government intervention in the health sector is bound to expand rather than contract because centralization is the key to reconciling otherwise divergent political demands for spending controls and greater equality of access to quality care for the increasing number of uninsured or underinsured persons."

Byron, Peg.
The health insurance conspiracy. Ms., v. 3, Sept.-Oct. 1992: 40-45.

Charges that "cost control in any form means income control for doctors, hospitals, insurers, and their ancillaries." Describes the plight of many who are uninsured, concluding, "Things are so bad in health care that U.S. citizens have to overcome their disgust with government to support universal health care through a national program."

Conyers, John, Jr.
Twelve principles for national health insurance reform. Journal of health care for the poor and underserved, v. 2, spring 1992: 423-426.

"Over the last year, I have spent considerable time meeting constituents, speaking with physicians, visiting hospitals, and holding Government Operations Committee hearings in Detroit and Washington on the health care problem. I also commissioned a major study by the General Accounting Office (GAO), the nonpartisan research arm of Congress, entitled Canadian Health Insurance: Lessons for the United States. Based on this work, I have identified 12 principles for reform."

Fei, Rashi.
Health care reform. Scientific American, v. 267, Nov. 1992: 46-53.

"Medical costs are rising rapidly, and millions of people have no health care coverage. The nation urgently needs a universal insurance program."

Fuchs, Victor R.
National health insurance revisited. Cambridge, Mass., National Bureau of Economic Research, 1991. 18 p. (Working paper no. 3884)

"This paper explains why one in seven Americans has no health insurance, and compares the casualty and the social insurance models of health insurance. The paper discusses the relationship among national health insurance (NHI), the cost of care, and the health of the population, and it considers the prospects for NHI in the United States in the short and the long run. Four explanations for the absence of NHI in the United States-- distrust of government, heterogeneity of the population, a robust voluntary sector, and lack of noblesse oblige--are evaluated in the light of recent political, social, and economic trends."

Goodman, John.
Beware of national health insurance. Washington, Heritage Foundation, 1990. 6 p. (Heritage lectures 276)

Looks at problems with health care systems when governments take control of a nation's health care resources.

Himmelstein, David U. Woolhandler, Steffie.
A national health program for the United States. New England journal of medicine, v. 320, Jan. 12, 1989: 102-106.

"A national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services, to establish overall spending limits."

How we can get responsible national health insurance. American enterprise, v. 3, July-Aug. 1992: 60-69.

"The plan that we outline in this article will achieve adequate insurance coverage for all Americans. Financial assistance is provided for those who need it in the form of tax credits. The plan encourages a vigorously competitive market; it turns to government only as needed to make markets work better. We call our plan Responsible National Health Insurance (RNHI). Its main features are outlined [in this article]."

Kopkind, Andrew.
Seizing the historic moment: national health care. Nation, v. 253, Dec. 16, 1991: 768-770, 772.

"The time has come to add health care to the structure of public prosperity in America," by instituting a national health system, the author argues. He fears that, instead, "crisis managers are sure to pick the least effective, most expensive and most class-divisive health care system."

Kosterlitz, Julie.
Softening resistance. National journal, v. 23, Jan. 12, 1991: 64-68.

"Though still wary of national health insurance, many businesses are entertaining a government role in health care reform, eyeing cost control methods such as tax penalties and uniform pricing."

Levey, Samuel. Hill, James.
National health insurance--the triumph of equivocation. New England journal of medicine, v. 321, Dec. 21, 1989: 1750-1754.

"In the United States, the federal government has traditionally been the agency of last resort, the final party to intervene on behalf of the public interest. For the protection of our health care system to be extended, either an upwelling of popular discontent or strong, active leadership is necessary. Without such ferment and leadership, the best we can hope for in the direction of universal health care is a series of half measures and fragmented financing mechanisms -- more equivocation."

Liberal benefits, conservative spending: the Physicians for a National Health Program proposal. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2549-2554.

"The physicians for a National Health Program proposes to cover all Americans under a single, comprehensive public insurance program without copayments or deductibles and with free choice of provider. Such a national health program could reap tens of billions of dollars in administrative savings in the initial years, enough to fund generous increases in health care service not only for the uninsured, but for the underinsured as well. We delineate a transitional national health program budget that would hold overall health spending at current levels while accommodating increases in hospital and physician utilization."

Moore, Gordon T.
Let's provide primary care to all uninsured Americans--now! JAMA [Journal of the American Medical Association], v. 265, Apr. 24, 1991: 2108-2109.

Argues that while comprehensive health insurance for the uninsured is being debated, the Federal Government, by prepaying participating physicians, could provide basic primary care services to the uninsured.

A Plan for 'responsible national health insurance.' Health affairs, v. 10, spring 1991: 5-25.

"Most of the new national health insurance proposals, like versions of national health insurance that have been proposed for decades, assume that substantial government involvement in the health care system is necessary to assure insurance coverage for all Americans and appropriate growth in health care expenditures. Our view is that excessive government intervention will make matters worse. Our strategy, therefore, is to design a scheme that limits governmental rules and incentives to the extent necessary to achieve the objectives."

Responsible national health insurance. By Mark V. Pauly et al. Washington, AEI Press; Lanham, Md., Distributed by arrangement with University Press of America, 1992. 87 p.

Seidman, Laurence S.
Reconsidering national health insurance. Public interest, no. 101, fall 1990: 78-88.

"Today, many conservatives oppose any government initiative concerning health insurance, and many liberals advocate mandated private health insurance with specific provisions. Conservatives seek to limit government regulation of medical providers and liberals hope to assure universal access to medical care without financial hardship. I will attempt to explain why both are mistaken: their strategies will not achieve their objectives. Instead, an income-related MRI is the best way both to limit government regulation of medical providers and to achieve universal access without financial hardship."

Stevens, Carol.
Why business is rushing to support NHI. Medical economics, v. 66, Aug. 21, 1989: 133, 134, 137-140, 143-144, 146.
"Exploding health costs have left employers shaken and angry. Many executives view national health insurance as the only solution."

Stone, Peter H.
National health insurance? Legal times (supplement), v. 14, Feb. 17, 1992: 11-12, 15.
Advises that the Health Insurance Association of America "is now mounting an aggressive lobbying and public-relations campaign to block national health insurance and to win the hearts and minds of politicians nationwide for more limited reforms."

U.S. Congress. House. Select Committee on Children, Youth, and Families.
The changing face of health care: the movement toward universal access. Hearing, 101st Congress, 1st session. Dec. 11, 1989. Washington, G.P.O., 1990. 201 p.
Hearing held in New Haven, CT.

Wasley, Terree P.
The coming push for national health care. Freeman ideas on liberty, v. 40, Jan. 1990: 30-31.
"Calls for some kind of national health care program have increased during the past year and are coming from a variety of sources. The rapid escalation in health care costs, particularly in the 1980s, and attention to the fact that approximately 30 million Americans lack health care insurance, have raised demands for some kind of universal solution."

Weil, Thomas P.
Is it time for NHI national health insurance? Best's review: life/health/insurance edition, v. 90, Apr. 1990: 32-34, 113-114.
Predicts "what seems inevitable in the 1990s is a national health insurance program enacted on a step-by-step basis and a far more restricted role for the private health insurance industry."

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Mental health services under a U.S. national health insurance plan. Hospital and community psychiatry, v. 42, July 1991: 695-700.
"Sometime during the 1990s, the U.S. Congress could enact legislation that would establish universal access to basic hospital and physician services and, later, create a national health insurance plan. The author explores the potential effect of these programs on state psychiatric facilities; short-term acute psychiatric care facilities, including those under for-profit ownership; mental health professionals; and delivery of patient care."

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A universal access plan: a step toward national health insurance? Hospital & health services administration, v. 37, spring 1992: 37-51.
Concludes that "the passage of a universal access plan is a necessary and incremental step that will provide additional time for the discussion of whether and, if so, when the United States will be prepared to implement the final steps toward a more single-payer, centrally controlled health care delivery system."

Wollstein, Jarret B.
National health insurance: a medical disaster. Freeman ideas on liberty, v. 42, Oct. 1992: 381-387.
Contends that an alternative to national health insurance is the removal of burdensome and costly government regulations that hinder a free market approach to health care.

### 3. Comparative and Foreign Health Care Systems

Altenstetter, Christa.
Hospital planners and medical professionals in the Federal Republic of Germany. In Controlling medical professionals: the comparative politics of governance. London, Sage Publications, 1989.

Atkinson, Carla.
Fact and fiction: a view from north of the border. Public citizen, v. 12, July-Aug. 1992: 19-21.

Canadian health policy analyst Jane Fulton has been traveling across the border for nearly 10 years to talk to health professionals and the public about her country's much-lauded and much-maligned system. Her outspoken, cut-and-dried talk on universal health care has made her a popular translator of the myths surrounding the Canadian system."

Barer, Morris L. Evans, Robert G.
Perspective: interpreting Canada: models, mind-sets, and myths. Health affairs, v. 11, spring 1992: 44-61.

Bigelow, Douglas A.
Comparative costs and impacts of Canadian and American payment systems for mental health services. Hospital and community psychiatry, v. 40, Aug. 1989: 805-808.

"In attempts to contain mental health costs, administrators are increasingly using incentives, competition, and accounting strategies and are creating more complicated financing systems. Yet the costs of these strategies and their impacts on the efficacy and efficiency of mental health services have yet to be studied. The authors compare mental health payment systems in British Columbia and Oregon."

Canada. Policy, Planning, and Information Branch. Ministry of Health and Welfare.
Health sector in Canada: fact sheets. Ottawa, 1989.

Canada's health care system: lessons for the United States? Washington, Employee Benefit Research Institute, 1989. 11 p. (EBRI issue brief no. 90)

Discusses Canada's "relative success in providing basic health care services," evidence in its low infant mortality rates. Notes weaknesses in the system's inflexibility, "administrative inefficiencies, supply shortages, [and] conflicts with providers."

Conklin, David W.
Why Canada's system is better and cheaper. Policy options, v. 11, May 1990: 16-18.

Concludes that Canadians have a better health care system, with more choices of what kind of care they receive and from whom, than most U.S. citizens have, even though Canada may not respond as quickly to developments in technology.

Controlling health expenditures--the Canadian reality. New England journal of medicine, v. 320, Mar. 2, 1989: 571-577.

"The Canadian approach has avoided or solved several of the more intractable problems facing the United States. In particular, overall health expenditures have been constrained to a stable share of national income, and universality of coverage (without user charges) eliminates the problems of uncompensated care, individual burdens of catastrophic illness, and uninsured populations."

Danzon, Patricia.
Hidden overhead costs: is Canada's system really less expensive? Health affairs, v. 11, spring 1992: 21-43.

"Examines the overhead costs of alternative health care systems, asserting that existing comparisons are grossly misleading...compares overhead costs under monopoly public insurance and competitive private insurance markets in general but draws on actual experience in Canada and the United States for empirical evidence."

Does Canada have the answer? Consumer reports, v. 57, Sept. 1992: 579-588.

"Examines the strengths and weaknesses of the Canadian system and evaluates the criticisms leveled against it."

Does U.S. health care need a dose of Canadian medicine? Business & health, v. 9, Nov. 1991: 34, 36-39, 42, 44-46.

Elaborates advantages and flaws in the Canadian health care system's possibility as a model for "radical changes necessary to achieve affordable universal health insurance" in the U.S.

Dunlop, Marilyn.

Health care Canadian-style. Public citizen, v. 12, July-Aug. 1992: 16-18.

"The Canadian approach to keeping its people healthy and treating them when they are sick may lack a few of the bells and whistles commonly associated with the United States' richer system, but most Canadians aren't prepared to trade."

France, George.

Cost containment in a public-private health care system: the case of Italy. Public budgeting & finance, v. 11, winter 1991: 63-74.

"Health care cost containment has become an important issue in Western countries in recent years. However, most efforts have met with only limited success and Italy is no exception. This article examines the mixed public-private system existing in Italy. It also describes and evaluates cost-containment efforts in the Italian public health care system."

Fuchs, Victor R. Hahn, James S.

How does Canada do it? A comparison of expenditures for physicians' services in the United States and Canada. New England journal of medicine, v. 323, Sept. 27, 1990: 884-890.

"This study concentrates on per capita expenditures for physicians' services because in this important sector the ratio between U.S. and Canadian spending is particularly large (1.72 in 1985). In other words, after adjustment for population size and the overall purchasing power of the Canadian dollar, Americans spend 72 percent more than Canadians for physicians' services. The comparable ratio for hospital expenditures is 1.34, and for all other health expenditures combined it is 1.30."

Graig, Laurene A.

Health of nations: an international perspective on U.S. health care reform. Washington, Wyatt Co., 1991. 263 p.

Haislmaier, Edmund F.

Northern discomfort: the ills of the Canadian health system. Policy review, no. 58, fall 1991: 32-37.

Concludes that "the U.S. political structure is fundamentally unsuited to effectively administering a national health system," particularly one with waiting lists. To some extent, "Canada's system serves well the majority who are reasonably healthy."

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Perception vs. reality: taking a second look at Canadian health care. Washington, Heritage Foundation, 1991. 20 p. (Backgrounder, no. 807)

"Far from being a model to emulate, the Canadian health care system is an alluring siren whose fetching appearance masks hidden dangers. Contrary to popular perception, Canada has failed to control the growth in health care spending. At the same time the clinical freedom so desired by doctors is being steadily taken away from Canadian physicians, while patients are forced to wait in lengthening lines for major treatments."

Haiven, Judy.

Medisscare. Mother Jones, v. 16, Mar. 1991: 51-53, 67-69.

"What the AMA and other enemies of our Canadian system seem to be banking on is the notion that people in the United States will turn up their noses at a good alternative if it can be made to seem ideologically impure, somehow un-American. The Americans I've met tend to be smarter than that."

Health care systems abroad. Hospitals, v. 65, May 20, 1991: 30-35.

Contents.--Looking abroad for changes to the U.S. health care system, by Mark M. Hagland.--Germany: universal coverage leads to efficiency, praise, by Mark M. Hagland.--Healthcare 'down under': success, with reservations, by Julie Johnson.--Two systems in change: Japan and the Netherlands, by Howard J. Anderson.

Health care systems in transition. Paris, Organisation for Economic Co-operation and Development, 1990. 204 p. (OECD social policy studies no. 7)

"Improved efficiency is an essential concern of attempts to reform health care systems in OECD countries. This collection of essays, by European and North American experts, reviews managerial tools and the philosophies underpinning the evolution of expenditure on health care."

Holzman, David.

Seeking cures for an ailing system. Insight (Washington times), v. 7, Apr. 8, 1991: 50-53.

"Most Americans are unhappy with the U.S. health care system. Add to that corporate frustration over the rising cost of employee benefits, and you have the makings of a reform movement. Some experts look to the universal care systems of Canada or Germany as the answer. But others see drawbacks in national programs and applaud the diversity of plans in the United States."

Horkitz, Karen.

International benefits: part one--health care. Washington, Employee Benefit Research Institute, 1990. 30 p. (EBRI issue brief no. 106)

Presents in graphic format information on private and public health insurance programs and health expenditures in the U.S. and several other countries: Australia, Canada, France, Germany, Great Britain, Japan, Netherlands, and Sweden.

Hughes, John S.

How well has Canada contained the costs of doctoring? JAMA [Journal of the American Medical Association], v. 265, May 8, 1991: 2347-2351.

"Canada's provinces have had varying success at containing the costs of physician services through the use of fee schedules and expenditure targets. This article examines the wide variation in the increases in the costs of physician services among Ontario, Quebec, and British Columbia between 1975 and 1987. Cost increases during that time resulted from various combinations of increases in prices (fees) and utilization, stimulated by an increased supply of physicians."

Hurst, Jeremy W.

Reform of health care in Germany. Health care financing review, v. 12, spring 1991: 73-86.

"For the past 45 years Germany has had two health care systems: one in the former Federal Republic of Germany and one in the former German Democratic Republic. The system in the Federal Republic was undergoing some important reforms when German reunification took place in October 1990. Now the system in eastern Germany is undergoing a major transformation to bring it more into line with that in western Germany."

Iglehart, John K.

Germany's health care system (Two parts). New England journal of medicine, v. 324, Feb. 14, 1991: 503-508; June 13: 1750-56.

Ikegami, Naoki.

Japanese health care: low costs, regulated fees. Health affairs, v. 10, fall 1991: 87-109.

Katz, Aaron.

The health care systems of British Columbia and Washington State: learning from the neighbors. Government finance review, v. 7, Dec. 1991: 21-26 p.

"Comparative data on the administration, performance and quality of health care in a northwestern state and its neighbor in Canada show the underlying influence of national cultures, economies and governmental structures on the two systems."

Kirkman-Liff, Bradford.

Health insurance values and implementation in the Netherlands and the Federal Republic of Germany. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2496-2502.

"The health care systems in the Netherlands and the Federal Republic of Germany are based on a set of values that involve mutual obligations between private parties. These obligations are realized through systems incorporating private practice physicians, community and church- and municipality-affiliated hospitals, and nonprofit and for-profit insurers. The underlying values and implementation approaches in these systems provide an alternative to the adoption of Canadian-style health insurance system."

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Physician payment and cost-containment strategies in West Germany: suggestions for Medicare reform. Journal of health politics, policy and law, v. 15, spring 1990: 69-99.

"The capitation rates are determined by negotiations between the physician associations and health insurers. The West German government has been able to exert some influence on the outcome of these negotiations through a quasi-governmental advisory body. Aspects of this structure could be adopted by Medicare in order to determine conversion factors for resource-based relative value scales or to create expenditure control and incentive structures for Medicare-participating physicians."

Kosterlitz, Julie.

But not for us? National journal, v. 21, July 22, 1989: 1871-1875.

Although the Canadian health care system "appears to offer some better alternatives to the pitfalls of the U.S. system . . . the biggest reason a Canadian system wouldn't work here, U.S. analysts say, is Americans' abiding mistrust of their government . . . . Critics argue that in a universal system, if push came to shove, it would succumb to public and special-interest pressures for more spending."

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Taking care of Canada. National journal, v. 21, July 15, 1989: 1792-1797.

"As America agonizes about soaring medical costs and the millions who lack health insurance, Canada's system illustrates the prospects and pitfalls of universal coverage."

Kritz, Fran.

Healthcare policy in perspective: a global view. Medical world news, v. 33, Apr. 1992: 12-13.

A round table at the National Managed Care Congress, March 1992 "brought together five experts on international managed care to point out the problems and reforms faced by national health care systems in Canada, Germany, the Netherlands, and Great Britain and the lessons that these experiences offer for the United States.

Lemieux, Pierre.

Socialized medicine: the Canadian experience. Freeman, v. 39, Mar. 1989: 96-100.

"Several lessons can be drawn from the Canadian experience with socialized medicine. First of all, socialized medicine, although of poor quality, is very expensive. A second lesson is the danger of political compromise. One social policy tends to lead to another. A third lesson deals with the impact of egalitarianism. Socialized medicine is both a consequence and a great contributor to the idea that economic conditions should be equalized by coercion."

Levin, Peter J. Wolfson, Jay.

Health care in the balance: Japanese eurythmy. Hospital & health services administration, v. 34, fall 1989: 311-323.

"Japan's health care delivery system fits neatly into the island nation's well-ordered, carefully balanced infrastructure. The organization and operation of Japan's health system reflects the quest for harmony and balance, or eurythmy, of Japanese culture. While Japan's economic success has attracted considerable attention among management scientists, the health care system that fuels and nurtures the health status of its hyperproductive workforce has not been a topic of much interest. The organization and management of Japan's health services delivery system are analyzed in this article."

Looking north for health: what we can learn from Canada's health care system. Edited by Arnold Bennett and Orvill Adams. San Francisco, Jossey-Bass, 1993. (The Jossey-Bass higher and adult education series)

This book will be available later in 1993.

Madore, Odette.

Established programs financing for health care. Ottawa, Research Branch, Library of Parliament, 1991. 18 p. (Background paper BP-264E (Aug. 1991))

Analyzes the past fifteen years of health care transfer payments from Ottawa to provincial governments. Assesses "the ability of certain provinces to maintain an adequate level of health care services, respect for national standards, and shared jurisdiction."

Marmor, Theodore R.
Canada's health-care system: a model for the United States? Current history, v. 90, Dec. 1991: 422-427.
Recommends the Canadian experiment with medical care for the U.S. as a "balance among cost, quality, and access."

Martin, Linda G.
Japan's golden plan for the elderly. Caring magazine, v. 11, Oct. 1992: 90-93.
"Faced with tremendous health care costs for its elderly, Japan has proposed a 10-year plan to lessen costs and put health care back into the community."

Morone, James A.
American political culture and the search for lessons from abroad. Journal of health politics, policy and law, v. 15, spring 1990: 129-143.
"This paper places the dialogue about health system lessons within the context of American political culture. It sketches out some of the distinctive dynamics in the American policymaking process. These dynamics help explain the problems we face, the programs we have pursued, and the alternatives we have forgone. The same political process which shaped past policies is likely to frame any lessons we try to import from abroad."

Munro, Ian R.
How not to improve health care. Reader's digest, v. 141, Sept. 1992: 49-53.
"Some in Congress think we can fix our problems by adopting Canada's plan. Before they vote, let's see how that system actually works."

Murdo, Pat.
Japanese health-care system no panacea for ailing U.S. program. JEI report, no. 25A, July 5, 1991: 1-17.
"Nearly universal access, choice of physician and hospital, shared premium costs, cross-group subsidies that help relieve any one group's burden, and fee systems that can respond to innovations in health care" in Japan must be "weighed against some of the negatives," including the "burden on the government to subsidize cost overruns and to regulate fees."

National health care: is it the answer? Canada-U.S. outlook, v. 2, Sept. 1991: whole issue (96 p.)
Contents.--Health care: what can the United States and Canada learn from each other? by David W. Conklin.--Philosophical underpinning of Canada's health care system, by Raisa B. Deber.--Is Canadian-style government health insurance the answer for United States' health care and access woes? by Edward Neuschler.--How to assess national health policy proposals and create the single best plan, by Paul W. Sperduto.

Navarro, Vicente.
A national health program is necessary. Challenge, v. 32, May-June 1989: 36-40.
"As the number of uninsured workers climbs, Americans with health coverage are paying more. In contrast, Canada's federally funded health care is more efficient and less inflationary."

Neuschler, Edward.
Canadian health care: the implications of public health insurance. Washington, D.C., Health Insurance Association of America, 1990. 100 p.
This study contributes "to the health care policy debate by describing the Canadian system, examining Canada's cost-containment and access record and assessing the fiscal implications for federal and state governments if a public health insurance entitlement were devised in the United States.

Paying physicians in Canada: minding our Ps and Qs. By Jonathan Lomas . . . [et al]. Health affairs, spring 1989: 80-102.

Pursuit of health systems reform. Health affairs, v. 10, fall 1991: whole issue (239 p.)
Partial contents.--Health care systems in twenty-four countries.--Soviet health care from two perspectives.--Japanese health care: low cost through regulated fees.--A different view of queues in Ontario.--Translating U.S. HMO experience to other health systems.--Health status in East European countries.--Cost control: Canada versus the United States.

Rakich, Jonathon S.
The Canadian and U.S. health care systems: profiles and policies. Hospital and health services administration, v. 36, spring 1991: 25-42.

"Comparisons are made in this article between the Canadian and U.S. health care insurance and delivery systems. Canada has universal, comprehensive, and publicly funded health insurance for medically necessary hospital and physician services. The United States does not. Aggregate health care expenditures for both countries are examined as are those for the hospital and physician services sectors. Policy differences between both systems, including system models, health insurance financing, resource commitment and control, and service limits, are presented. Observations are made regarding two elements of the Canadian model--prospective physician sector and prospective hospital global budgeting--and whether they are transplantable to the United States."

The Reform of health care: a comparative analysis of seven OECD countries. Health policy studies, no. 2. Paris, OECD, 1992. 152 p.

"This volume describes and assesses the reform path followed in seven European countries: Belgium, France, Germany, Ireland, the Netherlands, Spain and the United Kingdom. It outlines the principles adopted by most of these governments to monitor change, though the objectives remain despited budgetary constraints, to improve the health of their population in general as well as equitable access to health while respecting macro-economic equilibria."

Reihardt, Uwe E.
West Germany's health-care and health-insurance system: combining universal access with cost control. In U.S. Bipartisan Commission on Comprehensive Health Care, Supplement to final report, 1990. pp. 3-16.

Rochefort, David A.
More lessons, of a different kind: Canadian mental health policy in comparative perspective. Hospital and community psychiatry, v. 43, Nov. 1992: 1083-1090.

"The author concludes that universal insurance coverage patterned after the Canadian model would ameliorate only some problems faced by mentally ill persons in the United States. Mental health benefits must be structured to ensure the availability and organization of a full spectrum of long-term health care and supportive services."

Rodwin, Victor G. Grable, Harvey. Thiel, Gregory.
Updating the fee schedule for physician reimbursement: a comparative analysis of France, Germany, Canada, and the United States. Quality assurance, v. 5, Feb. 1990: 16-24.

Rosa, Jean-Jacques. Launois, Robert.
France. In Comparative health systems: the future of National health care systems and economic analysis, Jean-Jacques Rosa, ed. Greenwich, Conn., JAI Press, Inc., 1990.

Sabatino, Frank.
The delivery challenges posed by Canada: a bilateral view. Hospitals, v. 64, Nov. 5, 1990: 58, 60, 62, 64.

"American health care achieves islands of excellence, while countless millions lack access to health care or face economic destitution if struck seriously ill. The Canadian system achieves universal access, economic security, and effective cost control at the expense of innovation and independence."

Schieber, George J. Poullier, Jean-Pierre.
International health spending: issues and trends. Health affairs, v. 10, spring 1991: 106-116.

Schneider, Markus.
Health care cost containment in the Federal Republic of Germany. Health care financing review, v. 12, spring 1991: 87-101.

"Since 1977, cost containment has been an integral part of health policy in the Federal Republic of Germany. The common goal of the cost-containment acts was to bring the growth of health care expenditures in line with growth of wages and salaries of sickness fund members. The Health Care Reform Act of 1989 is the most recent manifestation of this policy. The main features of the numerous cost-containment acts are described in this article, and the effects of cost containment on supply and demand are analyzed."

Sheils, John F. Young, Gary J. Rubin, Robert J.
O Canada: do we expect too much from its health system? Health affairs, v. 11, spring 1992: 7-20.
"Canada's health program has been proposed as a solution to the most serious ills afflicting America's health care system . . . As proposed, Canada's model would replace the existing combination of private and public health insurance with a single public program that would protect all citizens from the financial consequences of illness."

Starfield, Barbara.
Primary care and health: a cross-national comparison. JAMA [Journal of the American Medical Association], v. 266, Oct. 23-30, 1991: 2268-2271.
"Ten Western industrialized nations were compared on the basis of three characteristics: the extent of their primary health service, their levels of 12 health indicators (e.g., infant mortality, life expectancy, and age-adjusted death rates), and the satisfaction of their populations in relation to overall costs of the systems." Canada, Sweden, and the Netherlands ranked high; the U.S. and West Germany ranked low on all three measures.

Terris, Milton.
Lessons from Canada's health program. Technology review, v. 93, Feb.-Mar. 1990: 27-33.
"Beyond a doubt, the Canadian medical-care system can teach the United States a lot about how to provide fair and humane health coverage. But in seeking solutions to the nation's medical woes, Americans must be prepared to learn from Canada's weaknesses, as well as its strength."

U.S. Congress. Senate. Committee on Governmental Affairs.
Cutting health care costs: experiences in France, Germany, and Japan. Joint hearing before the Committee on Governmental Affairs, United States Senate and the Special Committee on Aging, United States Senate, 102nd Congress, 1st session. Nov. 19, 1991. Washington, G.P.O., 1992. 192 p.
"Serial no. 102-15"

U.S. General Accounting Office.
Canadian health insurance: estimating costs and savings for the United States; report to the Honorable Nancy L. Johnson, House of Representatives. Apr. 28, 1992. Washington, G.A.O., 1992. 17 p.
"GAO/HRD-92-83, B-247625"
"Elements of a Canadian-style system continue to be reviewed as part of current discussions of health care reform. Analyses that attempt to estimate how U.S. health spending would change under a Canadian-style system all suggest significant potential for administrative savings. However, estimates vary more widely on the potential additional costs of increased utilization generated by the elimination of copayments. Appendix I provides a comparison of studies and the range of estimates."

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Canadian health insurance: lessons for the United States; report to the chairman, Committee on Government Operations, House of Representatives. June 4, 1991. Washington, G.A.O., 1991. 85 p.
"GAO/HRD-91-90, B-244081"
"Reviews Canada's universal, publicly funded insurance system . . . the policies used in this system, consequences for both health care spending and access, and implications for the United States."

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Health care spending control: the experience of France, Germany, and Japan; report to congressional requesters. Nov. 15, 1991. Washington. G.A.O., 1991. 70 p.
"GAO/HRD-92-9, B-244645"
"Describes these countries' methods of providing universal coverage through their health insurance and financing systems, their policies intended to restrain increases in health care spending, and the effectiveness of these policies."

Vance, Joan.
Health policy in Canada. 8 April 1988; revised 23 November 1990. Ottawa, Research Branch, Library of Parliament, 1990. 17 p. (Current issue review 88-6E)

Analyzes Government responsibility for health, financing the system, health policy, and a chronology of parliamentary action.

Walker, Michael.
Cold reality: how they don't do it in Canada. Reason, v. 29, Mar. 1992: 35-39.

"In Canada neither access to health care nor medical outcomes are equal. People wait longer in some provinces than in others, and some medical technology is available in some provinces but not others. Waiting, which is the only alternative for low-income Canadians, encourages high-income Canadians to go to the United States for treatment. The clear indication is that Americans should not adopt the Canadian health-care system in the mistaken belief that it will solve the problems of access and high cost."

Watsman, Nancy.
Socialized medicine now--without the wait. Washington monthly, v. 23, Oct. 1991: 43-46, 48-50.

"Despite the utopian claims of universal health care advocates, the problems with the Canadian system are real. Making it right for us will take hard work and, above all, brutal honesty about its flaws. But the end result will be advanced, humane medical care for all Americans. That it will also be billions of dollars cheaper than the jury-rigged, inequitable system we've got now--well, that's just added incentive to do the right thing."

Weil, Thomas P.
The German health care system: a model for hospital reform in the United States? Hospital & health services administration, v. 37, winter 1992: 533-547.

"Experience in Germany illustrates that the United States could potentially achieve universal access, comprehensive and high-quality services, and value for the money expended with what is often referred to as a 'quasi-private and quasi-public' health care system. The German hospital system is analysed from a number of perspectives, and it is concluded that this approach has some advantages over a single-payer, monolithic-type national health insurance model."

Wicks, Elliot K.
German health care: financing, administration, and coverage. Washington, Health Insurance Association of America, 1992. 70 p.

Document "gives particular attention to the role fo private health insurance in Germany."

Wilsford, David.
Doctors and the state: the politics of health care in France and the United States. Durham, Duke University Press, 1991. 355 p.

Wolfe, Samuel. Badgley, Robin F.
Universal access in Canada: questions of equity remain. Health/PAC bulletin, v. 22, fall 1992: 29-35.

"Wolfe and Badgley's insightful analysis of what they see as shortcomings of the Canadian model and suggestions for their remedy are especially welcome given the questionable validity of most criticism of the Canadian system that Americans hear. Their work helps us understand the real problems that remain in the still-evolving Canadian system. As Americans discuss the various possibilities for progressive single-payer reform, many envision a state-based system. Wolfe and Badgley point out that demographically rooted inequalities and the lingering health burdens of social class may interfere with truly national universal access. They also alert us to the dangers that federal retreat from adequate levels of support would pose to such a state strategy."

## C. REFORM PROPOSALS TO IMPROVE ACCESS TO HEALTH INSURANCE

### 1. General

An American approach to health system reform. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 253-254.

"Presents a reform option that would significantly expand insurance coverage and control costs with policies that are politically acceptable."

Bell, Nancy N.

From the trenches: strategies that work. Business & health, v. 9, May 1991: 19-20, 22, 24-26.

Provides a sampling of what nine companies are doing to hold down the cost of insuring the health of their workers.

Berman, Howard J. Klein, David.

Pieces of the puzzle: steps toward affordable health care. Hospital & health services administration, v. 37, spring 1992: 3-11.

Recommends "changing the most commonly held health insurance product to a plan with high-deductible design, and reinstituting community-based health planning."

Bertko, John. Pearman, AnnMarie.

A health plan designed by employees and physicians. Business & health, v. 9, Feb. 1991: 58, 60-61.

"At Mercy Healthcare Sacramento, a three-hospital system, we've attempted to design a benefits plan that recognizes employer/employee/provider interdependency. As a multi-hospital regional health care deliverer, Mercy knows both the medical and the business ends of health care. As a large Sacramento employer, Mercy faces many of the same health care cost problems as other employers. We hoped that by combining this triad of perspectives we could come up with a plan that worked."

Blendon, Robert J. Edwards, Jennifer N. Hyams, Andrew L.

Making the critical choices. JAMA [Journal of the American Medical Association], v. 267, May 13, 1992: 2509-2520.

"This article seeks to simplify the debate by identifying the critical choices that account for the main features of any national health plan . . . . The second part of the article presents tabular summaries of the proposals put forth by presidential candidates and members of Congress, proposals by national associations and prominent health care experts that have appeared in The Journal, and other important proposals; and we explain how each plan addresses the seven critical issues."

Bodenheimer, Thomas.

The major players start dealing: the health reform game. Nation, v. 256, Mar. 22, 1993: 374-376, 378-379.

California physician and member of Physicians for a National Health Program argues that managed competition is not the way to go to cover the uninsured or to control costs. "An effective, simple and popular proposal is available to him: a universal health insurance program that substitutes a single public insurer ("single payer") for the current multiple private insurance companies."

Bodenheimer, Thomas. Grumbach, Kevin.

Financing universal health insurance: taxes, premiums, and the lessons of social insurance. Journal of health politics, policy and law, v. 17, fall 1992: 439-462.

"Over the past century, most industrialized nations have developed highly popular social insurance programs to cover periods of retirement, disability, unemployment, and payment for medical care. Social insurance constitutes a blend of tax-like and premium-like features, offering lessons that might assist in breaking the current impasse over universal health financing."

Budetti, Peter.

Universal health care coverage—pitfalls and promise of an employment-based approach. Journal of medicine and philosophy, v. 17, 1992: 21-32.

"The time for systematic reforms has come and gone; what is now needed is action to prevent disaster, followed by a complete rebuilding of this country's health coverage system. Although perhaps more likely to be tried than more radical, completely nationalized, ones, stepwise reform may not go far enough to cure the significant ills of the current employment-based system. Passage of inadequate reforms, then, could well set the stage for nationalized health care in the not too distant future."

Burgess, James F., Jr. Stefos, Theodore.
Federal provision of health care: creating access for the underinsured. Journal of health care for the poor and underserved, v. 1, spring 1991: 364-387.

"The federal health care system for veterans is used as a model for exploring problems that must be solved in a universal access plan. The discussion focuses on the effects of competition for patients and health care resources on costs, innovation, regulation, and quality."

Burman, Leonard E. Rodgers, Jack.
Tax preferences and employment-based insurance. National tax journal, v. 45, Sept. 1992: 3331-346.

"The tax subsidy for employment-based insurance has been an important factor in the widespread access of middle- and upper-class working people to comprehensive health insurance and high quality medical care. The same tax subsidy, however, has played a major role in the explosion of medical costs and in the insurance problems of small firms. The high cost of insurance and health care compounds the problems of the uninsured."

Butler, Stuart M.
A tax reform strategy to deal with the uninsured. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2541-2544.

"The high level of uninsurance in the United States is due in large measure to the tax treatment of health care, which is based on the tax exclusion for company-provided plans. Correcting the perverse incentives for providers and patients resulting from this tax treatment is the crucial step to creating a national health care system that is affordable and efficient. The Heritage Foundation proposal calls for the elimination of the current tax exclusion and its replacement with a system of refundable tax credits for the purchase of health insurance and medical services."

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Using tax credits to create an affordable national health system. Washington, Heritage Foundation, 1990. 15 p. (Backgrounder no. 777)

Discusses the general goals of health care reform and the Heritage Foundation proposal that "would assure affordable access is health care for all Americans with little or no additional costs to the federal treasury." Provides answers to specific concerns about the proposal.

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Why "play or pay" national health care is doomed to fail. Washington, Heritage Foundation, 1991. 9 p. (Heritage lectures 329)

Revised version of testimony given to the Senate Committee on Labor and Human Resources on S. 1227 [HealthAmerica: Affordable Health Care for All American Act] on July 24, 1991. S. 1227 "would create a national health system in America on the 'play or pay' model. In this approach, U.S. companies would be given a choice: either provide a minimum specified package of health benefits to employees and their families, or pay a payroll tax to finance a public program to cover Americans not covered under company plans."

Callahan, Daniel.
Reforming the health care system for children and the elderly to balance cure and care. Academic medicine, v. 67, Apr. 1992: 219-222.

"In the area of health care reform, an entitlement program for the young is not the answer: society must overcome its unwillingness and put into place a universal health care system. Even with such a system, the health care needs of the elderly will continue to grow and absorb more resources, both because the percentage of elderly is rising and because developments in medical technology continue to create new treatment possibilities and expectations."

Cantor, Joel C.
Expanding health insurance coverage: who will pay? Journal of health politics, policy and law, v. 15, winter 1990: 755-778.

"Recent discussions on extending health insurance to the more than thirty million uninsured Americans have focused on two strategies: expanding the Medicaid program and mandating that employers sponsor coverage for their employees. This analysis, using a microsimulation model of the U.S. health care financing system, suggests that these two options would result in very different distributions of financial burden."

Cleeton, David L.
The medical uninsured. Public finance quarterly, v. 17, Jan. 1989: 55-83.
Argues "that the present design of public assistance programs creates a market failure by ruling out limited ceiling coverage for individuals who consider public assistance programs to provide at least partial coverage against losses. This is particularly relevant to the state Medicaid needy programs and their spend-down provisions."

Custer, William S.
Employer health care plan design and its effect on plan costs. Inquiry, v. 28, spring 1991: 81-86.
"This note describes the results of a study that examined the effects of employer health plan design on the delivery of health care services and on total plan costs. Employers in the Houston Area Health Care Coalition provided indemnity plan claims data for the years 1985-87. These data were used to examine the sources of plan costs by diagnosis and type of service. The data is also used to examine the relationship between elements of health care plan design and total plan charges."

The Demand for employment-based health insurance plans. Journal of human resources, v. 24, winter 1989: 115-142.
"Estimates show that employees are very sensitive to the out-of-pocket premium for each plan, controlling for other plan characteristics. These results are important both for public policy and for employers who offer multiple health plans."

Democratic Study Group.
Alternative approaches to health care reform. DSG special report, no. 102-8, July 22, 1991: 1-22.
Outlines proposals introduced by Democrats to the 102nd Congress, "plans achieving both universal coverage and systemic reform." Finds a consensus "that meaningful reform must promote universal health insurance coverage; the health insurance coverage provided must represent an adequate level of benefits; and the health insurance coverage provided must be affordable; . . . [and] the delivery of health care should remain in the hands of private-based physicians and hospitals, who can be freely chosen by consumers."

Diamond, Peter.
Organizing the health insurance market. Econometrica, v. 60, Nov. 1992: 1233-1254.
"This paper presents a new approach to organizing universal health insurance. First the government divides the entire population into many large groups. Then, the government creates a Federal Health Insurance System (HealthFed), modeled on the Federal Reserve System, to fill the role now played by the benefits office of a large firm. The HealthFed would create a short menu of alternatives, solicit bids for insuring the entire group, and price alternatives. There would be no connection between health insurance and employment."

Dixon, Jennifer.
US health care III: the reform problem. British medical journal, v. 305, Oct. 17, 1992: 941-944.
Examines "how far health care reform is a priority, the reform proposals on offer, and how acceptable they are to the key players in the health care arena. We also examine the action taken by the states and consider the likely course of reform in the future."

Durante, Alanne L. Durante, Salvatore J.
Medicare: prescription for a fool's paradise. Freeman ideas on liberty, v. 41, Apr. 1991: 140-144.
"This article aims to demonstrate, by a detailed look at Medicare, that such government interference in health care is harmful from the first to buyers and providers of health care, and in the long run is disastrous. Government medicine, on the national or the state level, is a prescription for a fool's paradise."

Ellwood, Marily Rymer. Burwell, Brian.
Access to Medicaid and Medicare by the low-income disabled. Health care financing review, 1990 annual supplement: 133-148.

"A series of options for restructuring program eligibility requirements are presented, with particular attention to improving the plight of the low-income disabled worker during the 24-month waiting period for Medicare. Options for Medicaid involve nationwide income eligibility levels at 100 percent of poverty and mandatory buy-in provisions to Medicaid in all States. For Medicare, the reforms range from altering the waiting period for Medicare by the disabled who are expected to die within 24 months after benefit award to eliminating the waiting period altogether."

Enthoven, Alain. Kronick, Richard.
A consumer-choice health plan for the 1990s: universal health insurance in a system designed to promote quality and economy. New England journal of medicine, v. 320, Jan. 5, 1989: 29-37.

Proposes "that everyone not covered by Medicare, Medicaid, or some other public program be enabled to buy affordable coverage, either through their employers or through a 'public sponsor.' To attack the excess, we propose a strategy of managed competition in which collective agents, called sponsors, such as the Health Care Financing Administration and large employers, contract with competing health plans and manage a process of informed cost-conscious consumer choice that rewards providers who deliver high-quality care economically."

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Universal health insurance through incentives reform. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2532-2536.

"Roughly 35 million Americans have no health care coverage. Health care expenditures are out of control. The problems of access and cost are inextricably related. Important correctable causes include cost-unconscious demand, a system not organized for quality and economy, market failure, and public funds not distributed equitably or effectively to motivate widespread coverage. We propose Public Sponsor agencies to offer subsidized coverage to those otherwise uninsured, mandated employer-provided health insurance, premium contributions from all employers and employees, a limit on tax-free employer contributions to employee health insurance, and 'managed competition.'"

Fein, Rashi.
The health security partnership: a Federal-State universal insurance and cost-containment program. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2555-2558.

"The Health Security Partnership attempts to assure (1) that all Americans have insurance coverage for a set of comprehensive health care benefits, (2) that cost-containment issues are addressed in a manner that does not impinge negatively on the quality of care, and (3) that provider freedom to deliver appropriate clinical care is strengthened. It assigns important responsibilities to the federal government (eg, specification of benefits, review of proposed state health care budgets), while permitting states to select, develop, and administer specific program design features they deem appropriate (eg, states could build on and expand the existing health system infrastructure, including private insurance, and/or extend the role of tax-supported programs). It is estimated that in its first year the program would add about 5% to America's health expenditures, but within a few years, cost-containment efforts and administrative efficiencies would reduce overall expenditures below what they otherwise would be."

A Framework for reform of the US health care financing and provision system. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2529-2531.

"Representing 100 businesses, insurers, providers and other employers throughout Kansas, the Kansas Employer Coalition on Health, Inc. is the state's primary voice for employers in matters of health policy. In 1987 the coalition's board resolved to supply private sector leadership to solve the problem of large numbers of uninsured Americans. When an internal committee presented a universal access model, the board returned it to the committee with instructions to include provisions for cost containment. In July 1989 the board endorsed the principles and general strategies of the framework that follows."

Frieden, Joyce.
Many roads lead to health system reform. Business & health, v. 9, Oct. 1991: 38, 40, 42, 44, 46, 48-50, 52, 54-55, 58, 62-66.

"To help sort out who the players are, what's at stake, and what grand scenarios are in store, Business & Health looks at the major categories of health reform plans and the problems they all try to solve. We also talk with individual employers and employer groups to find out what the business community thinks about the plans."

Gabel, John. DiCarlo, Steven. Sullivan, Cynthia. Rice, Thomas.
Employer-sponsored health insurance, 1989. Health affairs, v. 9, fall 1990: 161-175.

Gold, Marsha.
Health maintenance organizations: structure, performance, and current issues for employee health benefits design. Journal of occupational medicine, v. 33, Mar. 1991: 288-296.

"After summarizing the origins and key principles of HMOs, including the current characteristics of the HMO industry, this article reviews the evidence of HMO performance in the areas of benefits design, utilization and cost effectiveness, quality of care and consumer satisfaction, and selection and overall employer satisfaction. Outstanding issues and concerns, from the perspective of employee health benefits design, include issues such as assuring a fair price for HMO benefits, employer contribution methods, HMO diversification, and cost escalation and the search for value."

Goodman, John C. Robbins, Gary. Robbins, Aldona.
Mandating health insurance. Dallas, National Center for Policy Analysis, 1989. 21, 14 p.

Argues against proposals for mandated health insurance and concludes that "it would be far less expensive to subsidize unpaid hospital bills from public funds. And close inspection of the market for health insurance reveals that existing government regulation is a major cause of the rising number of people without health insurance. Before enacting new regulations, we should first repeal old ones and give market forces a chance to work."

Grannat, Diane.
That's not covered. Washingtonian, v. 25, Mar. 1990: 115-119, 177-178, 180-184.

"While Congress and the federal government are only now beginning to wrestle with the federal-employee health plan, private employers are already taking cost-cutting measures."

Haislmaier, Edmund F.
A cure for the health care crisis. Issues in science and technology, v. 6, spring 1990: 59-63.

Heritage Foundation analyst argues that "restoring consumer choice is the key to genuine and lasting reforms."

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The Mitchell HealthAmerica Act: a bait and switch for American workers. Washington, Heritage Foundation, 1992. 17 p. (Issue bulletin no. 170)

Predicts that passage of this bill with its incentives would "mean that the play or pay system quickly would collapse into a full-blown government-run, taxpayer financed, national health care system, with all the features of such systems that would be unacceptable to most Americans--long waiting lines for care, explicit rationing of care, and limits on a patient's choice of doctor and treatment."

Hall, Mark A.
Reforming the health insurance market for small businesses. *New England journal of medicine*, v. 326, Feb. 20, 1992: 565-570.

"Faced with possible extinction, the private health insurance industry has emerged as a vocal advocate of reforming .... With the rest of the debate over health care reform in gridlock, the basic structure of these measures has broad political support and is viewed by many as having a high likelihood of passage, both in individual states and early in the course of federal reform .... It is therefore imperative to understand precisely what small-group-market reform will and will not accomplish toward the twin goals of universal access and cost containment."

Harvey, Birt.
A proposal to provide health insurance to all children and all pregnant women. New England journal of medicine, v. 323, Oct. 25, 1990: 1216-1220.

Recommends a plan developed by the American Academy of Pediatrics which would replace Medicaid and give financial access to preventive, primary and major medical, and coordinated care to all children and pregnant women.

Health care reform. Employee benefit plan review, v. 47, Mar. 1993: 10-12, 14-16, 18-20, 22-26.

Examines "reform measures introduced thus far in the 103rd Congress. Many of the voices in the reform debate follow, including views expressed by the insurance industry, state governors, and employer and provider groups."

Herzlinger, Regina E.
Healthy competition: a third approach to the medical-insurance crisis. Atlantic monthly, v. 268, Aug. 1991: 69-81.

Suggests "enabling Americans to shop for their own policies" of medical health insurance through a combination of changes in the income tax codes and regulation of health insurance companies, rather than establish a national health insurance system or require all employers to provide insurance.

Is tax reform the key to health care reform? Edited by Stuart M. Butler. Washington, Heritage Foundation, 1990. 128 p. (Heritage lectures no. 296)

At head of title: A Heritage Foundation Conference.

"The Heritage Foundation in 1989 unveiled a bold strategy to address these concerns. It would create a national system that would reform the basic tax treatment of health care to give help where it is really needed and to introduce real incentives for sensible economies. The Heritage proposal generated enormous interest--and controversy. Heritage therefore assembled a distinguished panel of experts from government, industry, and the health care field for this working conference to scrutinize the plan, to test its central elements, and to refine it. Their discussions and criticisms are reprinted here."

Jones, Stanley B.
Employer-based private health insurance needs structural reform. Inquiry (Chicago), v. 29, summer 1992: 120-127.

"Argues that certain structural barriers in our employer-based health insurance system inevitably mean failure by employers, private insurers, and physicians to produce a system that provides affordable health care and insurance to the entire population with a minimum of government regulation and intervention. Key barriers that lead to failure in managing the physician-patient transaction and the competition among health care/health insuring plans are described. Finally, the minimal scale of needed reform is discussed."

Kavis, Karen.
Expanding Medicare and employer plans to achieve universal health insurance. JAMA [Journal of the American Medical Association], v. 265, May 15, 1991: 2525-2528.

"This article presents a plan to cover the entire US population by building on the two strongest elements of the current system--employer-provided health insurance and the Medicare program, which currently covers elderly and disabled persons--while instituting a new universal provider payment system to control rising costs. This plan would achieve greater efficiency and simplicity by establishing a common basic benefit package under both Medicare and employer plans, and establishing common provider payment methods applicable to both Medicare and employer plans. It would be financed through a combination of employer and individual premium contributions, payroll taxes, personal income taxes, and other general tax revenues."

Kosterlitz, Julie.
Unrisky business. National journal, v. 23, Apr. 6, 1991: 794-797.
"Both the health insurance industry and its critics agree that reforms are needed to guarantee medical coverage for small businesses and their employees. The question is, how sweeping will the changes be?"

Kronick, Richard.
Adolescent health insurance status: analyses of trends in coverage and preliminary estimates of the effects of an employer mandate and Medicaid expansion on the uninsured; background paper for the Office of Technology Assessment's Project on Adolescent Health prepared under contract. Washington, O.T.A., for sale by the Supt. of Docs., G.P.O., 1989. 73 p.
"OTA-BP-H-56, July 1989"
Examines the health insurance status of adolescents, age 10 to 18 years, using data from the Current Population Surveys, including March 1988 data from new questions from the health insurance supplement.

Lippert, Clare.
The Health insurance tax credit and Medicaid expansion: eligible populations. Washington, Health Insurance Association of America, 1991. 31 p.
"While less widely publicized than the changes in Medicaid, the tax credit is an innovative measure expected to complement Medicaid and to benefit many children."

McClure, Walter.
US health care: a better way. International economic insights, v. 3, Mar.-Apr. 1992: 37-40.
"Virtually all experts agree that the problems plaguing US health care and coverage stem from a single underlying cause: an unsound market .... Proposed solutions broadly divide into two camps: those that would make the private market sound; and those that would replace it with government controls."

Menke, Terri.
Universal health insurance coverage using Medicare's payment rates. Washington, Congressional Budget Office, for sale by the Supt. of Docs., G.P.O., 1991. 61 p.

Morone, James A.
Hidden complications: why health care competition needs regulation. American prospect, no. 10, summer 1992: 40-48.
"The great irony of market reform is that ... markets are not possible without subtle and extensive government regulation ... There is a simple, incremental, fully American, politically popular way to begin: expand Medicare to the entire population. There are also more elaborate ways to achieve a more just, efficient health care system. But none is more complex-to-describe, to legislate, to implement, or to administer--than the ostensibly simple notion of health care competition."

Morrisey, Michael A. Jensen, Gail A. Henderlite, Stephen E.
Employer-sponsored health insurance for retired Americans. Health affairs, v. 9, spring 1990: 57-73.

O'Neill, Paul.
Health care and American business: one CEO's view. Health affairs, v. 10, spring 1991: 76-86.
In this interview Paul O'Neill, CEO of the Aluminum Company of America, "expresses fear that the United States is headed inexorably down a road of developing a federally dominated national health insurance scheme, which he believes would result in a diminished system of care. Instead, O'Neill favors the imposition of a requirement on every citizen to purchase basic health insurance coverage, the cost of which would be treated as a tax credit, with public subsidies for people without the means to pay."

Reuler, James B.
Health care for the homeless in a national health program. American journal of public health, v. 79, Aug. 1989: 1033-1035.
"Removal of financial barriers to care by enactment of a national health program in the US would not solve all issues related to delivery of quality care for the homeless unless its structure addressed the special needs of disenfranchised groups."

Rice, Thomas.
Including an all-payer reimbursement system in a universal health insurance program. Inquiry (San Francisco), v. 29, summer 1992: 203-212.

"Examines the feasibility of including an all-payer reimbursement system in a universal health care program in the United States. An all-payer system would keep intact the current array of private and public insurers, but would require that they each pay the same price for hospital and physician services. The article concludes that an all-payer system would face far fewer political barriers than a purely government-financed system."

Salmon, J. Warren. Whiteis, David G.
Improving public health care: lessons on governance from five cities. Journal of health care for the poor and underserved, v. 3, fall 1992: 286-304.

"Policy-oriented investigations into public health care delivery have been limited, especially during the Reagan era of competition and profit-based health care, when the inner city was essentially forgotten. In this study, policymakers toured five urban public health care systems in different parts of the country to promote consideration of a new governance for Chicago and Cook County's complicated and uncoordinated care for the medically indigent. A comparison of patterns of governance revealed strengths and weaknesses of each model. Local leadership and the political will to evolve a system of care, with clear connections between the public and private sectors, account for each city's relative success in addressing mounting needs of inner-city populations."

Saltman, Richard B.
Single-source financing systems: a solution for the United States? JAMA [Journal of the American Medical Association], v. 268, Aug. 12, 1992: 774-779.

"Although tax-based and social insurance-based forms of single-source financing differ in how they raise funds, they share a common set of structural characteristics. In particular, they both enable publicly accountable authorities to control aggregate expenditure levels by creating a countervailing power to pressures for increased expenditures from providers. While major reform initiatives are under way in European single-source financing systems, these initiatives have so far sought to improve the efficiency, effectiveness, and/or responsiveness to patterns of service delivery without reducing their commitment to universal access to necessary care. The article concludes with a review of the advantages and disadvantages that could accompany the introduction of a single-source financing system in the United States."

Schramm, Carl J.
Government, private health insurance, and the goal of universal health care coverage. Inquiry (Chicago), v. 29, summer 1992: 263-268.

"The Health Insurance Association of America advocates joint efforts by federal and state governments and the private sector to achieve the goal of universal access to health care. It recommends several changes in the small employer market to provide greater predictability and protection to those insured, including establishment of private, not-for-profit reinsurance organisations authorised by the states. State risk pools for uninsurable individuals who are not part of an employer group are also proposed. The federal government role would include expanding Medicaid eligibility and exempting all insured plans from state mandated benefits. HIAA's proposal also stresses the continued growth and use of managed care programs."

Selected options for expanding health insurance coverage. Washington, Congressional Budget Office, for sale by the Supt. of Docs., G.P.O., 1991. 79 p.

"This study analyses two major approaches for substantially reducing the number of uninsured people. One would expand employment-based coverage, while the other would cover more people under Medicaid."

Small business and the National health care reform debate. Health affairs, v. 11, spring 1992: 164-173.

Discusses "the implications of current health care reform proposals for small businesses and their employees, drawing on this survey and others."

Snider, Sarah.
Features of employer-sponsored health plans. Washington, Employee Benefit Research Institute, 1992. 31 p. (EBRI issue brief no. 128)

Provides statistical information on health plan costs to employers, cost sharing, plan funding, health care delivery systems, nontraditional benefits, and retiree health coverage. Discusses some State and Federal initiatives.

Swartz, Katherine.
Why requiring employers to provide health insurance is a bad idea. Journal of health politics, policy and law, v. 15, winter 1990: 779-792.

"There is mounting pressure at the federal (and state) level to require employers to provide health insurance to their employees. However, two quite different groups of workers could be affected by such a mandate. In addition, there are at least five major problems with requiring employers to provide health insurance. Chief among these is the further fracturing of the insurance market, so that the spreading of risk will be reduced, and only the young and healthy will be offered insurance at relatively low premiums. We should be designing a health insurance system that has both universal coverage and a cost-containment structure. Toward this end, we need to tackle issues that transcend alternative methods of financing health care in the U.S."

Tapscott, Mark.
Health plan hot potato. Government executive, v. 21, Oct. 1989: 50-52.

"Thanks to factors largely beyond their control, selecting a health insurance plan each year during the November 'open season' can be an exasperating process for federal workers and annuitants. There is usually only one guarantee: Whatever is chosen will cost more."

Thompson, Roger.
Curbing the high cost of health care. Nation's business, v. 77, Sept. 1989: 18-20, 22, 24-26, 28-29.

Finds that "the surge in health-insurance premiums reflects the nation's unexpected failure to bring rising medical costs under control." Suggests alternatives to mandating employers to provide health insurance in a time of double-digit health costs inflation.

Thorpe, Kenneth E.
Expanding employment-based health insurance: is small group reform the answer? Inquiry (Chicago), v. 29, summer 1992: 128-136.

"Nearly two-thirds of all uninsured workers are employed in firms with 100 or fewer employees. Making insurance more affordable and available to small groups is high on the political agenda. Efforts to reform the small group market include making insurance more available by restricting the use of medical underwriting to deny access, and compressing rates to make it more affordable for high-risk groups. Other reforms pursued at the state level have focused on reducing the price of insurance facing all small employers. My analysis suggests that these proposals will have limited success in reducing the number of uninsured. Short of compulsory insurance, significant changes will occur only when insurance is organised around larger purchasing groups and not small employers."

Thorpe, Kenneth   Siegel, Joanna E.
Covering the uninsured: interactions among public and private sector strategies. JAMA [Journal of the American Medical Association], v. 262, Oct. 20, 1989: 2114-2118.

"This article examines the impact of two recent proposals to cover the uninsured on the cost of a Medicaid expansion. The first, an employer mandate (not specifically recommended by the Health Policy Agenda), would extend private sector coverage to the employed uninsured. The second, a Medicaid 'buy-in', would subsidize public sector insurance for the near poor. Implementation of these proposals in isolation or jointly would result in a dramatically different distribution of costs between the public and private sectors. Their impact on the cost of Medicaid reform highlights the importance of the broader debate concerning strategies for covering the uninsured."

Thorpe, Kenneth E. Siegel, Joanna E. Dailey, Theresa.
Including the poor: the fiscal impacts of Medicaid expansion. JAMA [Journal of the American Medical Association], v. 261, Feb. 17, 1989: 1003-1007.

"This article presents the fiscal impacts of the comprehensive reform of the Medicaid program put forth by the Health Policy Agenda for the American People. Proposed reforms include establishment of improved uniform eligibility standards, improvement in the scope and depth of coverage in state Medicaid programs, and increased provider payment rates. We estimate that expanding Medicaid coverage to all currently uninsured nonelderly persons below the federal poverty line would cost approximately $9 billion."

Tresnowski, Bernard R.
Building a foundation for universal access. Inquiry (Chicago), v. 29, summer 1992: 269-273.

"Specific strategies outlined by the Blue Cross and Blue Shield Association call for a restructuring of health care financing that builds on a competitive, employer-based health insurance system. Universal access can be achieved through better management of the cost of care and more affordable health care premiums. Restructuring of the financing system must restore its capacity to manage risk and establish accountability for managing cost. Business practices and public policies that have encouraged market fragmentation should be reformed and incentives to create affordable insurance options for all buyers be established."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Small market health insurance reform. Hearing, 102nd Congress, 2nd session. May 14, 1992. Washington, G.P.O., 1992. 250 p.

"Serial no. 102-157"

U.S. Congress. House. Committee on Post Office and Civil Service.
The Federal Employees Health Benefits Program: possible strategies for reform; a report prepared by the Congressional Research Service for the Committee on Post Office and Civil Services, U.S. House of Representatives. Washington, G.P.O., 1989. 361 p.

At head of title: 101st Congress, 1st session. Committee print 101-5.

Examines the current program's weaknesses and strengths, explores the health insurance experience of private and public employers, discusses methodologies to quantify cost/benefit comparisons, and develops a standardization of terms.

U.S. Congress. House. Committee on Ways and Means.
Comprehensive health insurance legislation, including H.R. 3205, the "Health Insurance Coverage and Cost Containment Act of 1991." Hearings, 102nd Congress, 1st session on H.R. 3205. Parts 1 and 2. Oct. 8-24, 1991. Washington, G.P.O., 1992. 2 v. (1549 p.)

"Serial 102-79" "Serial 102-80"

"To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States."

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Health insurance in the small group market. Hearing, 101st Congress, 2nd session. Apr. 3, 1990. Washington, G.P.O., 1990. 124 p.

"Serial 101-86"

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Health insurance options: expanding coverage under Medicare and other public health insurance programs. Hearing, 101st Congress, 2nd session. June 12, 1990. Washington, G.P.O., 1990. 150 p.

"Serial 101-111"

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Health insurance options: health insurance status of the indigent. June 27, 1991. Washington, G.P.O., 1992. 83 p.

"Serial 102-45"

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Health insurance options: proposals from the provider community. Hearing, 101st Congress, 2nd session. July 24, 1990. Washington, G.P.O., 1990. 67 p.
"Serial 101-106"

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Health insurance options: reform of private health insurance. Hearings, 102nd Congress, 1st session. May 2-23, 1991. Washington, G.P.O., 1992. 377 p.
"Serial no. 102-34"

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Private health insurance: options for reform. Washington, G.P.O., 1990. 55 p.
At head of title: 101st Congress, 2nd session, committee print WMCP: 101-35.

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Private health insurance reform legislation. Hearing, 102nd Congress, 2nd session on H.R. 2121; H.R. 1565; H.R. 3626. Mar. 12, 1992. Washington, G.P.O., 1992. 262 p.
"Serial 102-58"

"H.R. 2121.--To amend the Internal Revenue Code of 1986 to impose an excise tax on premiums received on health insurance policies which do not meet certain requirements; H.R. 1565.--To increase access to health care and affordable health insurance, to contain costs of health care in a manner that improves health care, and for other purposes; H.R. 3626.--To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for improvements in health insurance coverage through employer health insurance reform, for health care cost containment, for improvements in Medicare prevention benefits, and for other purposes."

U.S. Congress. Senate. Committee on Labor and Human Resources.
HealthAmerica legislation. Hearing, 102nd Congress, 1st session on S. 1227, examining reform of the nation's health care system to assure access to affordable health care for all Americans, focusing on health and economic implications. June 11-July 31, 1991. Washington, G.P.O., 1991. 2 v. (90, 265 p.) (Hearing, Senate, 102nd Congress, 1st session, S. Hrg. 102-322, pts. 1 and 2)

U.S. Congressional Budget Office.
Universal health insurance coverage using Medicare's payment rates.
Washington, For sale by the Supt. of Docs., G.P.O., 1991. 61 p.

Study examines "the potential effects on national health expenditures if health insurance were extended to the uninsured, and if all payers used Medicare's payment rates for physician and hospital services. The study provides illustrative estimates for two types of health care systems. The 'all-payer' system would retain the current mix of public and private insurers, but would require that all payers use Medicare's payment rates. The 'single-payer' system would replace the current multiplicity of insurers with a single public insurance plan that would cover all basic medical services."

U.S. General Accounting Office.
Private health insurance: problems caused by a segmented market; report to the chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives. July 2, 1991. Washington, G.A.O., 1991. 17 p.
"GAO/HRD-91-114, B-244435"

"Statement of Mark V. Nadel, Associate Director, National and Public Health Issues, before the Subcommittee on Health, House Committee on Ways and Means, May 2, 1991."

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Tax administration: administrative aspects of the health insurance tax credit; fact sheet for the chairman and the ranking minority member, Subcommittee on Health, Committee on Ways and Means, House of Representatives. Sept. 12, 1991. Washington, G.A.O., 1991. 9 p.
"GAO/GGD-91-110FS, B-245026"

Presents "basic description of how the recently enacted health insurance tax credit will work administratively. The health insurance tax credit is provided to low-income wage earners who contribute to a health insurance policy that includes coverage for at least one qualifying child. Because this credit is so new, you were interested in a description of how the Internal Revenue Service (IRS) intends to administer the credit and how the credit might be perceived by taxpayers."

U.S. health care system. Health affairs, v. 10, winter 1991: 170-188.

Contents.--The health insurance industry in the year 2001: one scenario, by Robert J. Blendon, Jennifer N. Edwards and Ulrike S. Szaly.--Insurance reform: industry, heal thyself! by Donald R. Cohodes.--A labor leader's view of insurance reform, by Lane Kirkland.--The promise of managed care: an insurer's perspective, by James T. Lynn.

Zedlewski, Sheila R. Acs, Gregory P. Winterbottom, Colin W.
Play-or-pay employer mandates: potential effects. Health affairs, v. 11, spring 1992: 62-83.

"This study estimates the range of potential effects of fully implemented play-or-pay employer mandates."

Zedlweski, Sheila. Holahan, John.
Expanding Medicaid to cover uninsured Americans. Health affairs, v. 10, spring 1991: 45-61.

"This article examines the effects of alternative Medicaid expansion strategies. We use microsimulation methods to estimate the cost and coverage implications of Medicaid expansion proposals that would cover nonelderly, noninstitutionalized individuals up to selected percentages of the poverty line. The analysis provides estimates of the number and characteristics of people affected, as well as implications for federal and state budgets. We show the full expansion costs and costs net of different types of buy-in arrangements. Finally, we consider the implications of combining employer mandates with expansions."

Zellers, Wendy K. McLaughlin, Catherine G. Frick, Kevin D.
Small-business health insurance: only the healthy need apply. Health affairs, v. 11, spring 1992: 174-180.

"It is likely that substantial financial incentives for these businesses will have to accompany any legislation that mandates employer-based health insurance."

### 2. State Proposals

American Legislative Exchange Council. National Task Force on Health Care.
Keeping the promise: making health care accessible and affordable for all Americans: a comprehensive health care plan for the States. Washington, The Council, 1993. 183 p.

"The nation's largest bipartisan, voluntary membership organization of state legislators. . . [presents a] comprehensive health care plan for the states based on a free market stategy." The plan is based on reform in the areas of insurance, Medicaid, medical liability, long-term care, and rural health care. Model legislation is included.

Beauchamp, Dan E. Rouse, Ronald L.
Universal New York health care: a single-payer strategy linking cost control and universal access. New England journal of medicine, v. 323, Sept. 6, 1990: 640-644.

"The New York State Department of Health has developed a proposal for universal access--Universal New York Health Care, or UNY-Care--that would retain the existing payers, including employer-based insurance coverage, but combine them in a one-payer framework. Providers would no longer have to interact with the many public and private payers, each with its own rules, criteria, and levels of payment. The single payer would serve as the only payer for most health care services and would also negotiate reimbursement rates."

Burke, Marybeth.
Hawaii's health care plan stirs Capitol Hill debate over access. Hospitals, v. 66, Apr. 20, 1992: 32, 34, 36.

"Hawaii has some incredibly important lessons to offer the nation. An employer mandate like Hawaii's would work in any state,' says Jack Lewin, M.D., Hawaii's director of health. However, some small businesses and policy analysts doubt the 'generalizability' of Hawaii's care system."

Caplan, Arthur L. Ogren, Paul A.
Do the right thing: Minnesota's HealthRight program. Hastings center report, v. 22, Sept.-Oct. 1992: 4-5.

"Unlike Massachusetts, the Minnesota plan does not mandate coverage or require small business to foot the bill for health insurance. Unlike Oregon, HealthRight does not explicitly ration care for the poor to expand access. Instead the Minnesota plan seeks to increase access by implementing a number of structural and institutional reforms to contain costs."

Cohn, Victor.

Rationing medical care: with Oregon in the lead, States are already deciding who does and who does not receive costly care. Public welfare, v. 49, winter 1991: 38-43.

"A blunt kind of medical rationing began three years ago in Oregon. It started a movement that could sweep the country. In July 1987, trying to stretch dollars for care of poor Medicaid patients, Oregon legislators voted to stop funding many organ transplants--cost, $65,000 to $250,000 apiece. They voted, instead, to use the money to give basic health services to 400 more women and 1,800 children."

Coye, Molly Joel.

Health care for the uninsured. Issues in science technology, v. 7, summer 1991: 56-62.

Credits at least 28 States with attempting to improve access to health care. "These experiments provide a valuable laboratory for learning about the feasibility, effectiveness, and limitations of approaches that the nation may ultimately use to resolve the critical and difficult issues of access."

Custer, William.

States and their role in the U.S. health care delivery system. Washington, Employee Benefit Research Institute, 1991. 15 p. (EBRI issue brief, no. 110)

"Many states are making important changes in the delivery and financing of health care that affect access, quality, and costs."

Dallek, Geraldine.

State initiatives on the medically uninsured: a survey. Santa Monica, Calif., Rand, 1990. 71 p. (Rand note N-3044-DOL)

"This Note was developed by the RAND Corporation's Center for the Study of Employee Health Benefits. It is the result of a year-long monitoring effort of State 1989 initiatives on the uninsured, which the Center undertook for the Pension and Welfare Benefits Administration of the U.S. Department of Labor. This document should be of interest to researchers and state and federal policymakers studying ways to improve health care coverage to the nation's uninsured."

Daniels, Norman.

Is the Oregon rationing plan fair? JAMA [Journal of the American Medical Association], v. 265, May 1, 1991: 2232-2235.

"Nationally, we should embrace Oregon's commitment to provide universal access to basic care and to make rationing a subject of open, political debate, but we should not simply expand the current legislation into a national plan. That would not only reproduce on a larger scale the unjustifiable inequality that the Oregon plan permits. It would also retain at the state level competition for funds between poor children and poor elderly, and it would leave unaddressed the basic problems of inefficiency and rapidly rising costs."

Demkovich, Linda.

The States and the uninsured: slowly but surely, filling the gaps. Prepared for the National Health Policy Forum. Washington, Distributed jointly by the National Health Policy Forum and the Intergovernmental Health Policy Project, 1990. 31 p.

Focuses on some of the innovative initiatives that States have taken in recent years to fill the gaps in insurance coverage.

Ervin, Mike.

CHIP: state program serving 4,000 uninsurable Illinoisans. Illinois issues, v. 18, Aug.-Sept. 1992: 30-32.

"The Illinois Comprehensive Health Insurance Plan (CHIP) is a microcosm of the huge dilemma of providing health insurance for those who can't get it. It covers a subset of the uninsured population in Illinois and cries for expansion."

Evaluation of the Oregon Medicaid proposal: summary. Washington, Office of Technology Assessment, 1992. 22 p.

"The goals of the OTA study were to describe and analyze the specifics of the proposed program and to discuss its most likely implications for the Federal Government, the State of Oregon, and Medicaid beneficiaries. The role of the report is not to critique the existing Medicaid program in detail. Rather, it is to examine the proposed program and especially its relevance to issues of particular interest to the

Federal Government: the impact of the program on Medicaid beneficiaries, in whom the Federal Government (as a copayer) has a fiduciary interest; and the potential usefulness of Oregon's program if applied in other States and other contexts."

Freedman, Marian.
Stating the case for health care reform. Best's review: life/health insurance edition, v. 92, Apr. 1992: 36-38, 40, 110-112, 114.

"While the congressional debate on health care reform rages, the states craft plans that could provide a model for national policy."

Gabel, Jon R. Jensen, Gail A.
The price of State mandated benefits. Chicago, v. 26, winter 1989: 419-431.

"States have passed more than 700 statutes mandating that insurers cover specific providers, diseases, or people who otherwise might have difficulty obtaining coverage. We report findings from three econometric studies that examine the effects of mandates on the cost of insurance, the small employer's decision to offer health insurance, and the large employer's decision to self-insure. Study results indicate that mandates raise the price of health insurance substantially; that nearly one of every six small firms that do not offer health insurance would in an essentially mandate-free environment, and that about half of the large firms that are converting to self-insurance would not if there were no mandates."

Goldberger, Susan A.
The politics of universal access: the Massachusetts Health Security Act of 1988. Journal of health politics, policy and law, v. 15, winter 1990: 857-885.

"This article analyses the passage of an unprecedented state law, promising every resident access to affordable health insurance. The Massachusetts Health Security Act of 1988 was the product of a set of political and financial pressures that had been developing for nearly a decade."

Hadorn, David C.
The problem of discrimination in health care priority setting. JAMA [Journal of the American Medical Association], v. 268, Sept. 16, 1992: 1454-1459.

Discusses explicit priority setting, such as in the Oregon Medicaid program. "Both of the key elements entailed by decision-analytic approaches to priority setting--estimation of outcomes and assignment of values to those outcomes--are vulnerable to charges of discrimination, primarily because both the medical outcomes expected in disabled individuals and the values they place on those outcomes may differ from the general public."

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Setting health care priorities in Oregon: cost-effectiveness meets the rule of rescue. JAMA [Journal of the American Medical Association], v. 265, May 1, 1991: 2218-2225.

"The Oregon Health Services Commission recently completed work on its principal charge: creation of a prioritised list of health care services, ranging from the most important to the least important. Oregon's draft priority list was criticised because it seemed to favor minor treatments over lifesaving ones. This reaction reflects a fundamental and irreconcilable conflict between cost-effectiveness analysis and the powerful human proclivity to rescue endangered life: the 'Rule of Rescue.' Oregon's final priority list was generated without reference to costs and is, therefore, more intuitively sensible than the initial list. However, the utility of the final list is limited by its lack of specificity with regard to conditions and treatments. An alternative approach for setting health care priorities would circumvent the Rule of Rescue by carefully defining necessary indications for treatment. Such an approach might be applied to Oregon's final list in order to achieve better specificity."

Hansel, Peter.
Expanding access to health care for California's uninsured population. Sacramento, Senate Office of Research, 1990. 41 p.

Contents.--Who are the uninsured?--Why is the number of uninsured increasing?--What impacts is the growth of the uninsured population having on the health care delivery system?--What options does the State have for expanding access to health care for the uninsured?--Funding sources for expanding health care for uninsured persons.

Health policy reform in America: innovations from the States. Edited by Howard M. Leichter. Armonk, N.Y., M.E. Sharpe, 1992. 220 p.

Improving access to health care: what can the states do? Edited by John H. Goddeeris and Andrew J. Hogan. Kalamazoo, Mich., W.E. Upjohn Institute for Employment Research, 1992. 273 p.

Jones, Katherine R.
The Florida Health Care Access Act: a blended regulatory and competitive approach to the indigent health care problem. Journal of health politics, policy and law, v. 14, summer 1989: 261-285.

"The problem of indigent health care has received much attention from governmental officials, health care providers, health policy analysts, and others. A majority of states have generated legislative proposals to deal with the problem, although their strategies differ in terms of method and scope. This article discusses Florida's approach to the problem as contained in the Health Care Access Act of 1984 and subsequent legislation."

Kitzhaber, John.
A healthier approach to health care. Issues in science and technology, winter 1990-91: 59-65.

"Faced with the lack of any clear federal leadership, we in Oregon came to realize that by default we had to assume responsibility for health care reform. This led us to develop the Oregon Basic Health Services Act, adopted in 1989 after an intensive legislative effort. The act was motivated by the desire to build a new system that recognizes the reality of fiscal limits, carefully defines the public policy objectives, and, most important, includes a mechanism to establish accountability for resource allocation decisions and for their consequences."

Kizer, Kenneth.
Health: a prescription for equity. California journal, v. 21, Jan. 1990: 55-59.

Examines factors that contributed to current inequity in health care and inflation of health care costs. Suggests ways to expand certain kinds of health care in California.

Kosterlitz, Julie.
Seeking the cure. National journal, v. 22, Mar. 24, 1990: 708-714.

"In the face of federal paralysis, state governments are trying to pioneer solutions to cost and access problems, and at the same time, find ways to pressure Washington to help with the things they say states simply can't do alone."

Kotelchuck, Ronda.

Medicaid managed care: a mixed review. Health/PAC bulletin, v. 22, fall 1992: 4-11.

"The Medicaid Managed Care Program is a major departure from previous New York State health policy. It will severely limit freedom for Medicaid recipients to choose their own providers, and it will sanction a fundamentally separate system of care for the poor. It will introduce incentives to reduce not only the cost of care, but the use of services as well. It will inject competition into New York's largely non-profit, highly regulated health care environment. it will create a major new player in New York's health system--the plan or HMO--and impose this player between the Medicaid program and medical providers. And, finally, it will create enormous demand for the most precious of commodities in New York--primary care providers willing to serve poor populations."

Kronick, Richard.

Can Massachusetts pay for health care for all? Health affairs, v. 10, spring 1991: 26-44.

"Many states and health policymakers nationwide are keeping a watchful eye on the Massachusetts plan to make health insurance affordable for all of its residents. Using a 'pay or play' tax, the plan requires employers to either provide health insurance for their employees or pay a tax of up to $1,680 per full-time worker. Opponents fear that the state government will require new general revenues (in addition to the pay or play tax monies) to keep its promise of health care for all. Opponents also fear businesses will close and unemployment will worsen because employers may not be able to afford the new tax. In this article, however, Richard Kronick shows that Massachusetts can make affordable health insurance available to all state residents without needing new funds from general revenues."

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The slippery slope of health care finance: business interests and hospital reimbursement in Massachusetts. Journal of health politics, policy and law, v. 15, winter 1990: 887-913.

"In 1988 Massachusetts enacted a bill, popularly known as Health Care for All, which promised that by 1992 every Massachusetts resident would have available affordable insurance for basic medical expenses. This legislation was one of a series of laws enacted over a period of six years which progressively improved access to care for the uninsured. The policy process which led to the enactment of these laws was strongly influenced by the interests of large employers. This article describes the series of access-expanding hospital reimbursement changes in Massachusetts in the 1980s and traces the connection between the involvement of business interests in the policy process and the outcomes that occurred; that is, it follows the slide of employers down the slippery slope of health care finance. The article also describes a potential implementation strategy for the Health Care for All legislation."

Lemov, Penelope.

Climbing out of the Medicaid trap. Governing, v. 5, Oct. 1991: 48-53.

"States are willing to try almost any innovation to get a grip on budgetary monster [Medicaid] that has so far been virtually uncontrollable. But the problem may be too much for any state to solve alone."

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Health insurance for all: a possible dream? Governing, v. 4, Nov. 1990: 56-59, 61-62.

"Two-thirds of the uninsured are employed or dependents of employees; many are self-employed or work for businesses too small to provide health benefits. If a state combines comprehensive pressure on the private sector with expanded Medicaid coverage, the numbers of the uninsured can decline considerably."

Little, Jane Sneddon.

Lessons from variations in State Medicaid expenditures. Federal Reserve Bank of Boston New England economic review, Jan.-Feb. 1992: 43-66.

"The pervasive theme emerging from this study of cross-state variations in Medicaid costs is that all health care in the United States--whether it is paid for by the public or the private sector, whether the patient is an employee of a big company or a small company, or not an employee at all- should be reimbursed according to the resources absorbed in providing this care. A growing demand for equal access and a growing need for efficiency require policymakers to steer the health care system in this direction."

Lumsdon, Kevin.

Beyond tech assessment: balancing needs, strategy. Hospitals, v. 66, Aug. 5, 1992: 20-26.

The transplant dispute in Oregon highlights the national debate over health care and access. "Much like the state's controversial proposal to rework its Medicaid program, the transplant dispute has become a proxy for a broader concern, this time involving the evaluation and use of medical technology in hospitals. At issue is how hospitals decide to add new services and equipment--and what these decisions mean in terms of systemwide costs."

Marcus, Leonard J.

Universal health insurance in Massachusetts: negotiating policy compromise. Journal of aging & social policy, v. 1, 1989: 33-59.

"The Massachusetts Health Security Act is the first universal-access financing legislation in the country, and sets a precedent for providing health coverage for the 600,000 uninsured in the state. The bill is the product of prolonged negotiation among hospitals, business interests, insurers, and advocates of universal access, who debated the extent of benefits, the cost of care, and the system which will monitor and regulate its provision."

McCall, Nelda. Jay, E. Deborah. West, Richard.

Access and satisfaction in the Arizona health care cost containment system. Health care financing review, v. 11, fall 1989: 63-77.

"The Arizona Health Care Cost Containment System is an alternative to Medicaid's acute medical care coverage. The results of the study indicate few differences in access and satisfaction between the two groups of beneficiaries on access to care, reported use of services, or satisfaction with the care received."

Morell, Virginia.

Oregon becomes a test case for health care reform. Science, v. 257, Aug. 1992: 1202-1203.

"Earlier this month, Oregon's pioneering health care rationing plan, which would provide health insurance for all Oregonians at the expense of not covering some expensive procedures, was rejected by the Bush Administration on surprising grounds. Secretary of Health Louis Sullivan told the state he could not approve its proposal because, the Administration contends, the Oregon plan violates the 1990 Americans with Disabilities Act (ADA)."

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Oregon puts bold health plan on ice. Science, v. 249, Aug. 3, 1990: 468-471.

Discusses Oregon's plan that only medical procedures with the best cost-benefit ratios should be financed, as a way to ration Medicaid services. Reports unexpected complications found by the Oregon Health Services Commission.

National Coalition of Hispanic Health and Human Services Organizations.

. . . And access for all: Medicaid and Hispanics. Washington, The Coalition, 1990. 147 p.

Gives overall findings and data on Arizona, California, Florida, Illinois, New Jersey, New York State, and Texas. Recommends that we "break Medicaid's link with public cash assistance categorical qualification and provide universal coverage for all persons living below the poverty level . . . . Eliminate the assets test and mandate use of presumptive eligibility and continuous eligibility options under State Medicaid coverage of pregnant women and children . . . . Increase the bilingual caseworker capacity of Medicaid application sites . . . . Increase use of Hispanic community-based organizations as satellite application sites and in Medicaid information efforts."

National Governors' Association.

A Healthy America: the challenge for the States. Washington, The Association, 1991.

Nelson, Robert M. Drought, Theresa.

Justice and the moral acceptability of rationing medical care: the Oregon experiment. Journal of medicine and philosophy, v. 17, 1992: 97-117.

"The Oregon Basic Health Services Act of 1989 seeks to establish universal access to basic medical care for all currently uninsured Oregon residents. To control the increasing cost of medical care, the Oregon plan will restrict funding according to a priority list of medical interventions. The basic level of medical care provided to residents with incomes below the federal poverty line will vary according to the funds made available by the Oregon legislature. A rationing plan such as Oregon's which potentially excludes medically necessary procedures from the basic level of health are may be just, for the right to publically-sponsored medical care is restricted by opposing rights of private property. However, the moral acceptability of the Oregon plan cannot be determined in the absence of knowing the level of resources to be provided. Finally, Oregon to date has failed to include the individuals being rationed in discussions as to how the scarce resources are to be distributed."

New Jersey's Medicaid waiver for acquired immunodeficiency syndrome. Health care financing, v. 13, spring 1992: 27-44.

"This article contains data from a study of New Jersey's home and community-based Medicaid waiver program for persons with symptomatic human immunodeficiency virus illness. Major findings include lower hospital costs and utilization for waiver participants compared with general Medicaid acquired immunodeficiency syndrome admissions in New Jersey. Average program expenditures were $2,400 per person per month. Based on study findings, it is evident that the waiver program is an important means of providing financial benefits and access to services and that comprehensive case management is a critical factor in assuring program quality."

Robinson, Eric Lamond.

The Oregon Basic Health Services Act: a model for State reform? Vanderbilt law review, v. 45, May 1992: 977-1014.

Note concludes that "although it has yet to be implemented, OBHSA already is playing a significant role in the future of health care delivery in this country. Experts predict that, sooner or later, our health care delivery system will have no choice but to ration health care services explicitly. OBHSA provides a model or equitable health care reform worthy of consideration, but to maximize the benefits of the health care delivery system, future legislation must address more comprehensively the problem of waste."

Rodat, John.

Analyzing health data. Empire State report, v. 17, Oct. 1991: 19-22, 24.

"Without proper data on the health care service patterns and patients in the state, lawmakers cannot begin meaningful debate on the state's health policies. This study reveals ways in which the state can track information necessary to making informed decisions."

Sager, Alan. Socolar, Deborah. Hiam, Peter.

Lessons from the failure of Massachusetts' 1988 Universal Health Insurance Law. Journal of aging and social policy, v. 4, no. 1-2, 1992: 9-15.

"The real lessons from Massachusetts are three: First, a badly designed law is hard to implement. Second, the money to cover uninsured Americans can and should be found in the bowels of current health spending. Third, universal access, health care finance, and health care cost control have to be undertakent simultaneously and incrementally. A brief review of the provisions of the 1988 Massachusetts law and of how they were implemented provides support for this position."

Shortell, Stephen M.

A Model for state health care reform. Health affairs, v. 11, spring 1992: 108-172.

"Americans generally favor local problem solving and control over federally mandated appoaches, even though local approaches are not always more effective. Thus, health care reform that features a prominent role for the federal govenment is not likely to be Americans' first choice; we are likely ot make better progress by focusing on reforms at the state and local levels, where health care is actually delivered."

Soloway, Fred J.

Hawaii leads the way to universal health insurance. Public employee, v. 56, June-July 1991: 4-8.

"Massachusetts passed a more modest measure in 1988--that has faced serious implementation problems during the subsequent economic downturn--and efforts are under way in other states to pass mandatory health insurance laws. But Hawaii remains the only state in the U.S. that has made serious headway toward universal health insurance coverage."

The Statehouse prescription. American prospect, no. 9, spring 1992: 51-63, 65-66.
Contents.--Why the States can't solve the health care crisis, by Deborah A. Stone.--States first: the other path to national health reform, by John E. McDonough.

The Uninsured and the debate over the repeal of the Massachusetts universal health care law. JAMA [Journal of the American Medical Association], v. 267, Feb. 26, 1992: 1113-1117.

"The debate in Massachusetts over the repeal of the first state-based 'pay or play' universal health plan is discussed using data from a survey of 1066 Massachusetts households. The survey attempted to measure the problems of the uninsured, to estimate the likelihood that they would pay insurance if offered, and to calculate the proportion of the uninsured who would be covered under an employer mandate."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
HealthRight: Minnesota's proposed health care access legislation. Hearing, 102nd Congress, 2nd session. Apr. 3, 1992. Washington, G.P.O., 1992. 153 p.
"Serial no. 102-123"

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Oregon Medicaid rationing experiment. Hearing, 102nd Congress, 1st session. Sept. 16, 1991. Washington, G.P.O., 1991. 277 p.
"Serial no. 102-49"

"The State proposes to ration services to those low-income women and children who are now eligible for Medicaid, and the savings from this rationing will help to pay for the extension of coverage to all of the uninsured who are in poverty . . . . In order to get Federal dollars on these terms, Oregon needs a change in Federal Medicaid rules," which it is requesting in the form of five years of waivers. Testimony from Governor Barbara Roberts, Jean Thorne (Director of the State's Medicaid program), and supporters and opponents nationwide is included.

U.S. Congress. House. Committee on Small Business. Subcommittee on Antitrust, Impact of Deregulation, and Privatization.
State efforts to increase the availability and affordability of health insurance. Hearing, 101st Congress, 2nd session. Aug. 10, 1990. Washington, G.P.O., 1990. 172 p.
Hearing held in Tulsa, OK.
"Serial no. 101-76"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Establishment of State risk pools to provide health coverage for uninsured Americans. Hearing, 101st Congress, 1st session. May 25, 1989. Washington, G.P.O., 1989. 95 p.
"Serial 101-48"

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Health insurance options: State mandates on health benefits. Hearing, 102nd Congress, 1st session. July 29, 1991. Washington, G.P.O., 1992. 149 p.
"Serial 102-53"

"State mandates generally take one of three forms: . . . coverage for specific types of services . . . reimbursement for certain types of providers . . . coverage for certain types of individuals or groups, such as newborn children or dependent students."

U.S. General Accounting Office.
Health care spending: nonpolicy factors accounts for most State differences; report to the Honorable Richard H. Bryan, U.S. Senate. Washington, G.A.O., 1992. 25 p.
"GAO/HRD-92-36, B-246979"

"In most states, per capita spending on personal health care is near the U.S. average. In over half the states, spending levels are within 10 percent of the national average. Many states with higher spending levels are concentrated in the Northwest, Midwest, and Far West, while many states with lower per capita spending are in the South and Rocky Mountain regions. Estimates for 1990 indicate that Massachusetts had the highest health expenditures per capita--over $3,000; South Carolina had the lowest expenditures--less than $1,700 per capita."

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Medicaid: Oregon's managed care program and implications for expansions; report to the chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives. June 19, 1992.
Washington, G.A.O., 1992. 62 p.
"GAO/HRD-92-89, B-246496"

"This report reviews the Oregon Medicaid managed care program and the state's proposal to expand the program as part of a larger demonstration. The report reviews issues of access, quality of care, and financial oversight."

Wicks, Elliot K. Haugh, Kevin. Curtis, Richard E.
An analysis of the Garamendi plan for health reform in California. Conducted for the Henry J. Kaiser Family Foundation. Washington, Institute for Health Policy Solutions, 1992. 80 p.

California Insurance Commissioner John Garamendi's proposal, made in "California health care in the 21st century: a vision for reform," is summarized and analyzed. It is described as a unique combination of features of a government-finance 'single-payer' system with those of a market-based system, while providing universal coverage and cost-containment strategies. Unresolved issues, including the often overlooked "separate lives of medical, workers' compensation, and automobile insurance," are discussed.

Wiener, Joshua M.
Oregon's plan for health care rationing: bold initiative or terrible mistake. Brookings review, v. 10, winter 1992: 26-31.

"Although the plan is controversial in several respects, the most revolutionary part of the package is Oregon's solution to the increasingly severe problem of providing medical care to the poor. The state will guarantee care to all Oregonians below the poverty line, but at a price: the explicit and public rationing of their medical care."

Wilson, Brenda L.
The terrible cost of treating everyone. Governing, v. 4, Jan. 1991: 26-32.

"There are more than 200,000 people in metropolitan Atlanta alone who do not have any health insurance. Grady Memorial is, in effect, their insurer. The residents and attending physicians, nurses and other hospital staff at Grady are as close as many will ever come to having a family doctor. The uncompensated care Grady provides has to be paid for out of the appropriations it receives from the counties of Fulton and DeKalb and the state of Georgia. It costs an enormous amount, more every year, and the money is getting harder to come by."

Yawn, Barbara P. Jacott, William E. Yawn, Roy A.
MinnesotaCare (HealthRight): myths and miracles. JAMA [Journal of the American Medical Association], v. 269, Jan. 27, 1993: 511-515.

Despite several name changes due to trademark conflicts, this health reform package focuses "on health care cost containment, providing insurance for some of the uninsured, recommending managed care for all, calling for research regarding use of practice parameters and new technology, all without any new income or employer taxes." Evaluates this State law providing a "subsidized minimal benefit insurance package for low-income families and insurance reform to lower the cost of insurance for small businesses."

# III. RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD CONTROL HEALTH CARE COSTS FOR ALL UNITED STATES CITIZENS

## A. GENERAL

The 1991 National Executive Poll on Health Care Costs and Benefits. Business & health, v. 9, Sept. 1991: 61-71.

Charts by Donna Covello and Ron Scalici convey in graphic format responses by 421 company executives in a May 1991 questionnaire by the journal. Rising health insurance premium costs are of key concern to many.

Aaron, Henry J.
Serious and unstable condition: financing America's health care. Washington, Brookings Institution, 1991. 158 p.

Administrative costs in the U.S. health care system: the problem or the solution? Inquiry (Chicago), v. 29, fall 1992: 308-320.

"Overall, the papers and presentations emphasized that while the focus of attention has been on the controversy over whether particular aggregate estimates of administrative costs and potential savings are correct, the fundamental underlying issue is how the health care system might best be managed.

APACHE-L: a new severity of illness adjuster for inpatient medical care. Medical care, v. 30, May 1992: 445-452.

"There is a need for a severity of illness measure that is easily obtained from computerised hospital data, objective, clinically valid for adjusting expected resource use, and can be used as an aid to quality of care efforts. At the study hospital, the APACHE-L score was able to explain substantial amounts of intra-DRG resource variation and appeared to be a potentially important new severity of illness adjuster for DRGs and merits further evaluation."

Baker, Alex.
An ounce of prevention. Business & health, v. 9, Dec. 1991: 30, 32-34, 36-37.

"As data accumulate on the cost advantages of prevention, more companies and their insurers are likely to offer prevention programs. The key to understanding the value of prevention, however is that it is not the be-all and end-all of health care. Prevention is simply one more piece of the puzzle. When used in conjunction with wellness programs and lifestyle management, prevention can have a significant impact on the health care bottom line."

Battistella, Roger M.
Health spending in an age of financial limits. Human ecology forum, v. 17, winter 1989: 10-13, 32.

"The value of health spending enjoyed a prolonged era of confidence after the Second World War and prodded the health industry into an enormous period of growth. But national health policy has since become the scene of controversy, indecision, and doubt. The author looks behind this national mood change at changes sweeping through health services and what they predict for the future."

Berenson, Robert. Holahan, John.
Sources of the growth in Medicare physician expenditures. JAMA [Journal of the American Medical Association], v. 267, Feb. 5, 1992: 687-691.

"Increases in the number and average age of enrollees, increases in physician fees, and increases in the number and intensity of services" account for the rise in expenses under Part B of Medicare.

Betley, Charles.
Prescription drugs: coverage, costs, and quality. Washington, Employee Benefit Research Institute, 1992. 22 p. (EBRI issue brief, no. 122)

Concludes that, "recent changes in Medicaid reimbursement seem likely to result in higher prices for private payers. Health care quality may be enhanced by public and private utilization review and other activities to improve the way physicians prescribe drugs."

Burner, Sally T. Waldo, Daniel R. McKusick, David R.
National health expenditures projections through 2030. Health care financing review, v. 14, fall 1992: 1-29.
"If current laws and practices continue, health expenditures in the United States will reach $1.7 trillion by the year 2000, an amount equal to 18.1 percent of the Nation's gross domestic product (GDP). By the year 2030, as America's baby boomers enter their seventies and eighties, health spending will top $16 trillion, or 32 percent of the GDP.

Christensen, Bryce J.
In sickness and in health: the medical costs of family meltdown. Policy review, no. 60, spring 1992: 70-72.
The decline of the family in recent decades has contributed both to serious health problems and to rising health care expenditures, especially by government. Conversely, one of the best ways to improve Americans' health care would be to favor policies that strengthen families.

Clinton, Bill.
Putting people first: a national economic strategy for America. Little Rock, Ark., Bill Clinton for President Committee, 1992. 21 p.
"To reclaim the future, we must strive to close both the budget deficit and the investment gap . . . . To pay for these investments and reduce our national deficit, I will save more than $360 billion by cutting spending, closing corporate tax loopholes, requiring the very wealthy to pay their fair share of taxes, and implementing rigorous health care cost controls."

Clinton/Gore National Campaign.
Controlling costs and guaranteeing care for all--the Clinton/Gore health care plan. Little Rock, Clinton/Gore National Campaign, 1992.

Cohen, Steve.
Malpractice: behind a $26-million award to a boy injured in surgery. New York, v. 23, Oct. 1, 1990: 40, 42-46, 48-49.
Staggering malpractice awards may be the only means of shocking the medical profession into purging incompetent members from their ranks, but it also drives the cost of medical care up and may discourage good doctors from practicing medicine.

Cole, Gerald E., Jr.
How will companies cope with the skyrocketing costs of retiree health benefits? Employee benefits journal, v. 14, Sept. 1989: 2-6, 10.
Outlines options that may help employers cope with escalating costs, proposed changes in accounting procedures, and legal constraints.

Collective bargaining in 1990: health care cost a common issue. Monthly labor review, v. 113, Jan. 1990: 3-18.
"Escalating health insurance premiums are likely to be a common threat in the fabric of this year's bargaining."

Conroy, M. Mary.
Physician, cut thy costs. Business & health, v. 9, June 1991: 38, 40, 42, 46, 48, 50-51, 54, 56.
"Everybody knows that health care costs are out of control--everybody, that is, except physicians. But now even the providers are getting the economy message and considering taking part in the cost cutting battle."

The Cost of health care. State government news, v. 33, May 1990: 6-7, 9-18, 20-23.
Contents.--No magic bullet for health insurance costs, by Elaine S. Knapp.--Ways to cut America's health bill, by Joseph A. Califano, Jr.--Health care gap swallows millions, by Michael S. Dukakis.--States lessen Alzheimer's burden, by Cheri Collis.--AIDS overwhelms health systems of major U.S. cities, by Linda Wagar.

Custer, William.
Issues in health care cost management. Washington, Employee Benefit Research Institute, 1991. 17 p. (EBRI issue brief, no. 118)
"It has often been stated that a decade of cost management has not slowed health care cost inflation . . . . Although still in an early stage of development, objective

measures for evaluating the quality of care and comparing health outcomes with the cost of treatment are beginning to influence the health care services market."

Dentzer, Susan.
How to fight killer health costs. U.S. news & world report, v. 111, Sept. 23, 1991: 50-53, 54, 56-58.

"Businesses must confront the real forces that are driving up costs, such as the absence of economic incentives for truly cost-effective health care. Firms must also become intelligent health-care buyers, searching far more diligently for the best deals around. Companies must accept the job of providing most of the nation's health insurance in exchange for powerful new tools to contain health costs. And above all, firms must recognize that new laws or national policies alone won't get the job done."

Dixon, Jennifer.
US health care II: the cost problem. British medical journal, v. 305, Oct. 10, 1992: 878-880.

"Examines why the costs of health care have risen, their effects, and the efforts to contain costs in relation to four groups of Americans--those with no health insurance, those with government funded health insurance through Medicare (the health programme for the elderly) and through Medicaid (the health programme for the poor), and those with private health insurance."

Driving down health care costs: strategies & solutions, 1990. Greenvale, N.Y., Panel, 1989. 241 p.

"Health care has finally gained a spot on the national agenda--witness the number of related bills pending in Congress or even the Newsweek cover that asked 'Can You Afford to Get Sick?" But responsibility for containing those costs still lies largely where it has always been--with those who design and administer health benefits. This is not to suggest that employers must be victims of the situation--far from it. This edition of driving down Health Care Costs describes not only what employers might do, but also what they have done to control, or even reduce, health care costs."

Eppinger, Frederick H. Hollen, James B.
Controlling runaway health care costs. Best's review: life/health/insurance edition, v. 91, Oct. 1990: 37-38, 40, 158, 160, 162.

"Historically, most insurance carriers and their customers have considered group insurance a commodity. Today, nothing could be farther from the truth. Chief executives and chief financial officers are paying serious attention to their company's medical benefits plans--what they offer and what they cost."

Epstein, Arnold M. Stern, Robert S. Weissman, Joel S.
Do the poor cost more?: a multihospital study of patients' socioeconomic status and use of hospital resources. New England journal of medicine, v. 322, Apr. 19, 1990: 1122-1128.

"After excluding outliers and adjusting for diagnosis-related group (DRG), [the authors] found that the patients of the lowest socioeconomic status had hospital stays 3-30 percent longer than those of higher status . . . . Supplementary payments to hospitals for the treatment of poor patients merit further consideration."

Fisher, Rhona S. Jones, Judith Miller.
Business-led collective purchasing: a new frontier. Washington, National Health Policy Forum, 1992. 13 p. (Issue brief no. 606)

Background paper for a technical briefing on business coalitions involved in "new alliances" in order "to improve their capacity to make better decisions about cost-effective [health] care and [to] obtain the cooperation of providers in delivering such services . . . . [They] hope to change attitudes and behaviors . . . leading to a higher-order, community-conscious partnership that will offer the whole community more value for each health care dollar spent."

Fleming, Steven T.
The relationship between quality and cost: pure and simple? Inquiry, v. 28, spring 1991: 29-38.

"This study focuses on the relationship between the quality and the cost of hospital care."

Frieden, Joyce.

Fraud squads target suspect claims. Business & health, v. 9, Apr. 1991: 21-24, 26, 28, 30, 31-33.

"Fraudulent health insurance claims are costing health insurers $60 billion each year."

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Health care costs: the shift goes on. Business & health, v. 10, Mar. 1992: 49-50, 52-54.

"The trend among federal and state governments has been to control how much they pay for health care by increasing spending at less than the rate of health care inflation. The result is that businesses and other buyers have complained that they are forced to pay more for health care."

Frieden, Joyce. Kisner, Kathleen.

The quest for quality data. Business & health, v. 10, Aug. 1992: 28-36.

"Health care buyers are gathering data on provider quality and costs and using it to improve the effectiveness of their health plans."

Gleicher, Norbert.

Expansion of health care to the uninsured and underinsured has to be cost-neutral. JAMA [Journal of the American Medical Association], v. 265, May 8, 1991: 2388-2390.

"Any attempt to address the problem of more than 30 million uninsured and 25 million seriously underinsured citizens in the United States has to be able to offer medical services to this 20% of the population in a cost-neutral way for the US economy, since present economic conditions do not permit further expansion in health care costs. A medical system compartmentalised by medical specialty should be able to save approximately 20% of present-day health care expenditures within each specialty, which then can be used to provide the necessary coverage."

Gronfein, William P. Kinney, Eleanor DeArman.

Controlling large malpractice claims: the unexpected impact of damage caps. Journal of health politics, policy and law, v. 16, fall 1991: 441-464.

"Indiana's comprehensive malpractice reforms, inaugurated in 1975, include a cap on damages, a mandated medical review before trial, and a state insurance to pay claims equal to or greater than $100,000. We have found that the amount of compensation going to claimants with such large malpractice claims in Indiana is, on average, substantially higher than in Michigan and Ohio."

Grumbach, Kevin. Lee, Philip R.

How many physicians can we afford? JAMA [Journal of the American Medical Association], v. 265, May 8, 1991: 2369-2372.

"In this report, we examine physician supply in the United States from a different perspective--that of costs. Rather than addressing the question 'How many physicians do we need?' we explore the question question 'How many physicians can we afford?' As health care costs as a percent of the US gross national product approach 12%, there is concern the nation cannot continue to support such rapid growth in health care spending."

Harris, Jeffrey S. Custer, William S.

Health care economic factors and the effects of benefits plan design changes. Journal of occupational medicine, v. 33, Mar. 1991: 279-286.

"Medical benefits costs now exceed 13% of payroll, up from 5% in the early 1980s. Full reimbursement for more expensive hospital-based care, a technology and specialist supply explosion funded by Medicare and Medicaid, and cost shifting from these programs to private insurance have fueled this rapid growth. Benefits plans, which had provided essentially free care, have been changed slowly and incrementally to increase cost sharing and, thus, cost sensitivity on the part of employees.

Health spending: the growing threat to the family budget. Washington, Families USA Foundation, 1991. 9 p.

"This report analyzes, for the first time, the total burden of health care spending on American families and businesses, nationally and state-by-state, for the years 1980, 1991 and 2000. Also provided is data on the sources of payments by families and businesses."

Health spending through 2030: three scenarios. Health affairs, v. 10, winter 1991: 231-242.
Four health statistics analysts offer projections for national health expenditures for various scenarios of future health care consumption trends.

Helms, Robert B.
Future issues in health economics: one view from Washington. Quarterly review of economics and business, v. 30, winter 1990: 23-31.
"These are comments about how policy issues at the federal level may create a demand for research in several areas of health economics. As background, there is a discussion of the current federal budget situation and the cost-containment pressures this puts on public health programs. The long-term problem of financing of the Medicare trust fund is also discussed. Four areas where new research may affect future health policy are identified: the market for physician's services, medical technology, competition in health care, and the market for health insurance."

Herzlinger, Regina E.
The failed revolution in health care--the role of management. Harvard business review, v. 67, Mar.-Apr. 1989: 95-103.
"The American health care industry is sick. Its huge fraction of our GNP--one out of every eight dollars--is double that of Japan and at least 50% higher than that of other developed countries. Because it is growing at rates 50% higher than the GNP, the industry's cost hampers control of our disastrous trade deficit."

High-tech health care: who will pay? Business week, no. 3090, Feb. 6, 1989: 74-76, 78.
"New medical technologies can save lives--at a price. And that price, many experts say, is already too high high for society to bear."

Hildebrandt, Paula. Thomas, Cric A.
The rising cost of medical care and its effect on inflation. Federal Reserve Bank of Kansas City, v. 76, Sept.-Oct. 1991: 47-58.
"Does the relatively fast pace of inflation in medical care pose a problem for policymakers? This article argues that high inflation in medical care makes achieving price stability more difficult, but that its effect on overall inflation is not large enough to inhibit policymakers from pursuing price stability as a goal."

Hoffman, Alan N. Nurick, Aaron J.
Choosing health care coverage: considerations of physicians motivation. Business horizons, v. 34, May-June 1991: 67-71.
"The central focus of this article is to explain how physicians are compensated and explore how compensation may affect the quality of the health care provided."

Hojnacki, William P.
Health care costs in the U.S.: the role of special interests. Journal of social, political and economic studies, v. 15, fall 1990: 337-355.
"Our purpose . . . is to attempt to put into perspective the various interests that have an influence in the production and consumption of health care services. We hope this paper will represent an initial step toward understanding the forces behind the dramatic increase in health care costs that American society has experienced over the last several years."

Holahan, John. Dor, Avi. Zuckerman, Stephen.
Understanding the recent growth in Medicare physician expenditures. JAMA [Journal of the American Medical Association], v. 263, Mar. 23-30, 1990: 1658-1661.
"This study employs several large Health Care Financing Administration data sets for 1983 and 1985 to examine the recent growth in Medicare physician services. The study concludes that the recent growth (approximately 15% in real terms between 1983 and 1985) has been more rapid in areas with higher incomes per capita and suggests that this may be related to faster adoption and diffusion of new medical technologies in these areas."

Holahan, John. Zedlewski, Sheila.
Who pays for health care in the United States? Implications for health system reform. Inquiry (Chicago), v. 29, summer 1992: 231-248.
"We analyse the distribution of employer and employee contributions to health insurance, private nongroup health insurance purchases, out-of-pocket expenses, Medicaid benefits, uncompensated care, tax benefits due to the exemption of

employer-aid health benefits, and taxes paid to finance Medicare, Medicaid, and the health benefit tax exclusion."

Horkits, Karen.
Health care: what role in the U.S. economy? Washington, Employee Benefit Research Institute, 1991. 23 p. (EBRI issue brief, no. 114)

"The 12 percent of GNP Americans spend on health care services--twice the amount spent on defense and three-quarters of the amount spent on manufacturing--finances millions of jobs and accounts for billions of dollars in revenues."

Jecker, Nancy S. Pearlman, Robert A.
An ethical framework for rationing health care. Journal of medicine and philosophy, v. 17, 1992: 79-96.

"This paper proposes an ethical framework for rationing publicly-financed health care. We begin by classifying alternative rationing criteria according to their ethical basis. We then examine the ethical arguments for four rationing criteria. These alternatives include rationing high technology services, non-basic services, services to patients who receive the least medical benefit, and services that are not equally available to all. We submit that a just health care system will not limit basic health care to persons unable to pay for it. Furthermore, justice in health care requires limiting publicly-financed non-basic health care, striving for equality in access to basic health care, and relying on medical benefit to ration non-basic health care."

Kinzer, David M.
Why the conservatives gave us universal health care: a parable. Hospital & health services administration, v. 34, fall 1989: 299-310.

"The health sector has been on a competitive binge that was supposed to contain cost increases, but aggregate expenditures for health care are rising on about the same curve as before. As Americans continue to spend more for health services, more health care providers, insurers, and 'managed care' enterprises are in deep financial trouble . . . . This is a parable of one of the things that could happen."

Kirchner, Merian.
Who pays for new technology? Business & health, v. 9, Oct. 1991: 20, 22, 24-25.

"The explosion of new medical technology over the past 20 years has fueled an even more explosive rise in health care spending. Health economists estimate that the use, misuse, and overuse of all the procedures, devices, and drugs in today's high-tech armamentarium--from organ transplants to diagnostic imaging equipment to powerful new cancer-fighting chemicals--account for about 40 percent of the annual increase in total health care costs."

Kosterlitz, Julie.
Bottom-line pain. National journal, v. 21, Sept. 9, 1989: 2201-2205.

Describes reactions from corporations to rising health care costs, including efforts to influence the "quality of care" and to reduce costs for employee health insurance.

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The growth industry. National journal, v. 23, Nov. 30, 1991: 2917-2920.

Looks at health care reform as an economic issue. What value do consumers get for their money? What effect do medical and health insurance costs have on the economy as a whole?

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Rationing health care. National journal, v. 22, June 30, 1990: 1590-1595.

"The limits-to-medicine school . . . [claims] that the demand for care outstrips Americans' ability or willingness to pay for it." Current debate over medical ethics is reported, particularly in light of Oregon's controversial efforts to revamp its Medicaid program.

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Wanted: GPs. National journal, v. 24, Sept. 5, 1992: 2011-2015.

"Too many physicians are being trained as specialists and not enough as generalists. As a result, the nation's health care system emphasizes high-cost, high-technology medicine at the expense of basic and preventive care."

Kovach, Kenneth A.

Health care cost containment: an impossible dream? Labor law journal, v. 42, Oct. 1991: 660-664.

"The escalating cost of employee health care has become a major threat to the balance sheet of most major U.S. employers. No human resource issue has consumed as much time and energy, or generated as much anxiety, since the Employee Retirement Income Security Act of 1974 forced employers to come to grips with the solvency of their pension plans."

Langwell, Kathryn. Menke, Terri.

Rising health care costs: causes, implications, and strategies. Washington, Congressional Budget Office, for sale by the Supt. of Docs., G.P.O., 1991. 90 p.

"The study suggests that efforts to control health spending may be frustrated by our fragmented financing system, under which providers who face constraints on prices and amounts of services for one set of patients may be able to compensate by increasing the prices they charge and the services they extend to other patients. Gaining control over health care costs would apparently require a significant restructuring of our health care system. To achieve greater control over costs we would have to make certain concessions. For example, there would probably be less spending on research and development, longer waiting times for use of new technologies, and limitations on our choices of providers and health care coverage."

Lanning, Joyce A.

The health care quality quagmire: some signposts. Hospital & health services administration, v. 35, spring 1990: 39-54.

"Escalating price competition in healthy care has pushed providers and purchasers to scramble for outcome measures to use as indicators of minimum acceptable quality. This article suggests that health care managers assist purchasers in developing quality measures that include patient perceptions in addition to technical competence and also build a general philosophy that values quality."

Leahy, Richard E.

Rational health policy and the legal standard of care: a call for judicial deference to medical practice guidelines. California law review, v. 77, Dec. 1989: 1483-1528.

"The expanding application of sophisticated technology to medical practice, and its attendant costs, has created the need for medical practice guidelines for physicians. It remains unclear, however, which authorities should be responsible for developing these guidelines, and how these guidelines should be received by courts when adjudicating medical negligence claims. This Comment addresses these issues, and contends that professional medical societies are the most appropriate authorities for developing and promulgating practice guidelines."

Levit, Katharine R. Cowan, Cathy A.

The burden of health care costs: business, households, and governments. Health care financing review, v. 12, winter 1990: 127-137.

"In this article, the authors recast health care costs into payer categories of business, households, and Federal and State-and-local governments which are more useful for policy analysis. The burden that these costs place upon the financial resources of each payer are examined for 1989 and for trends over time. For businesses their share of health care costs continues to creep upward compared with other payers and relative to their own resources, despite many changes they are making in the provision of employer-sponsored health insurance to their employees."

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Business, households, and governments: health care costs, 1990. Health care financing review, v. 13, winter 1991: 83-93.

"During the last decade, health care costs continued to grow at annual rates of 8 to 16 percent. Burden measures show that rapidly rising costs faced by each sponsor sector are exceeding increases in each sector's ability to fund them."

Makin, John H.

Runaway health costs. American enterprise, v. 1, Jan.-Feb. 1990: 52-57.

"Between 1965 and 1985, the U.S. gross national product (GNP) grew fivefold, while spending on health care grew tenfold. If that trend continues, as indeed it has so far, a male child born in 1988 with a life expectancy of 71 years would see all of our GNP devoted to health care spending at the time of his death. These figures are another way of saying that some changes must be made to reduce the growth in spending on health care."

Marmor, Theodore R.
American health politics, 1970 to the present: some comments. Quarterly review of economics and business, v. 30, winter 1990: 32-42.
"This article reviews the attempts of the 1970s and 1980s to rationalize health care provision in the United States. It critically discusses the contorted debate between competition and regulation as a means of controlling health care costs."

Medical malpractice: a report prepared at the request of the House Committee on Ways and Means by the Education and Public Welfare Division and the American Law Division of the Congressional Research Service, Library of Congress. Washington, for sale by the Supt. of Docs., Congressional Sales Office, G.P.O., 1990. 116 p.
At head of title: 101st Congress, 2nd session. Committee print.
"April 26, 1990."
"WMCP: 101-26."

Meyers, Ann L.
Spreading the word: talking to employers and consumers about the health care cost crisis. Broker world, v. 11, June 1991: 12-16, 180-184.

Moffit, Robert E.
Comprabile worth for doctors: a severe case of government malpractice. Washington, D.C., Heritage Foundation, 1991. 22 p.
"Unless Congress and the Administration order the government's regulatory machine to reverse gear . . . . Medicare continually will have to update arbitrary and incomprehensible 'values' for thousands of different medical procedures."

Mullan, Fitzhugh. Rivo, Marc L. Politzer, Robert M.
Doctors, dollars, and determination: making physician work-force policy. Health affairs, special supplement 1993: 138-151.

Musgrave, Gerald L.
Health care cost limitation: individual responsibility. Vital speeches, v. 55, Feb. 15, 1989: 273-276.

National health expenditures, 1990. Health care financing review, v. 13, fall 1991: 29-52.
"During 1990, health expendituress as a share of gross national product grew to 12.2 percent, up from 11.6 percent in 1989. This dramatic increase is the second largest increase in the past three decades. The national health expenditure estimates presented in this article document rapidly rising health care costs and provide a context for understanding the health care financing crisis facing the Nation today."

Newhouse, Joseph.
Medical care costs: how much welfare loss? Journal of economic perspectives, v. 6, summer 1992: 3-21.
"Some proposed health [care] 'cost containment' policies may result in welfare losses for the insured, and even increase the number of uninsured."

Nyman, John A.
Costs, technology, and insurance in the health care sector. Journal of policy analysis and management, v. 10, winter 1991: 106-111.
"There is growing evidence that the root cause of cost inflation in the health care sector is technological change, which is caused in turn by the prevalence of health insurance. At the same time, the high costs of high-tech care mean that more and more people are now forced to buy insurance in order to gain access to health care under all contingencies. Forcing people to buy insurance in order to have access to health care can result in a welfare loss to society. This paper argues that in order to stop the increases in health care expenditures and reduce this welfare loss, we may need to consider policies aimed at constraining the development of new technologies. If we do not adopt these policies, we may be forced to accept the otherwise inexorable increases in health care costs."

Oliver, Thomas R.
Health care market reform in Congress: the uncertain path from proposal to policy. Political science quarterly, v. 106, fall 1991: 453-477.
"Oliver looks at the national debate over health care reform of a decade ago and congressional policy decisions on the issue. He analyzes why Congress rejected proposals to stimulate broad competition in the financing and delivery of health care

services and instead enacted a more narrow system to regulate hospital costs for the Medicare program."

Patterns of outpatient prescription drug use among Pennsylvania elderly. Health care financing review, v. 12, spring 1991: 61-72.

"The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) provides outpatient prescription drug coverage for nearly one-half million State residents 65 years of age or over with income under $15,000 per year. A description of the PACE program is provided herein, along with data and multivariate results relating to the demographic characteristics of PACE beneficiaries, duration of enrollments, drug utilization and expenditure rates, average prices for covered prescriptions, and drug expense distributions."

Pfaff, Martin.

Differences in health care spending across countries: statistical evidence. Journal of health politics, policy and law, v. 15, spring 1990: 1-67.

"There is a strong presumption that health care systems relying on some overall control of spending generally are more cost-effective than those relying more on decentralized mechanisms of control. Services are more equitably distributed in relation to health and payment for health services is far more progressive in the former type of system."

Rather, Jonathan.

The high cost of health. GAO journal, no. 13, summer-fall 1991: 3-23.

"So today it is a commonplace that our health system is in crisis. But this label is too facile if it suggests imminent collapse. Rather, the painful paradox of our health system--the coexistence of American medicine's continued successes with its persistent gaps and inefficiencies--is becoming more acute. To understand that paradox better, we must explore the high, and rising, level of our health-care spending."

Reisch, Marc S.

Companies face big jump in costs of health benefits for retirees. Chemical & engineering news, v. 70, Mar. 1992: 17-21.

"The costs of keeping retirees healthy is about to bring a big and unwelcome jolt to corporate finances. Because of a new accounting requirement, companies that provide health care benefits to their retirees will have to set aside millions, even billions, of dollars on their books to account for the costs of these benefits."

Relman, Arnold.

Confronting the crisis in health care: an interview with Arnold Relman. Technology review, v. 92, July 30, 1989: 30-38, 40.

Discusses health care, the role of new technologies in the crisis, the need for physicians to alter the way they practice medicine, and the changes likely to occur in the years ahead. Relman is editor of the New England Journal of Medicine.

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What market values are doing to medicine. Atlantic monthly, v. 269, Mar. 1992: 99-102, 105-106.

"The former editor in chief of the New England Journal of Medicine fears that his profession has lost its ethical way. Doctors, he argues, are not, and should not be, businessmen, and yet financial and technological pressures are forcing more and more of them to act like businessmen, with deleterious consequences for patients and for society as a whole."

Sabatino, Frank.
Vendors worry: will health reform place technology on trial? Hospitals, v. 66, Nov. 5, 1992: 34, 36, 38.

"Health care vendors are keenly aware that the reform proposals being floated in Washington and in state capitals will help determine their business prospects well into the next century. Among the core questions are those concerning technology diffusion and marketing. Are we as health care consumers spending too much money and energy developing and acquiring the latest health care technology? Who controls technology diffusion and the introduction of new products, including pharmaceuticals?"

Schwartz, William B. Aaron, Henry J.
Must we ration health care? Best's review, life/health/insurance edition, v. 91, Jan. 1991: 37, 39-41.

"The United States is running out of ways to painlessly offset the unrelenting increase in health care costs. Denial of benefits to even affluent persons may become common in the years ahead."

Shelton, Jack K. Janosi, Julia Mann.
Unhealthy health care costs. Journal of medicine and philosophy, v. 17, 1992: 7-19.

"The private sector has implemented many cost containment measures in efforts to control rising health care costs. However, these measures have not controlled costs in the long run, and can be expected not to succeed as long as business cannot control factors within the health care system which affect costs. Controlling private sector health care costs requires constraints on cost shifting which necessitates a unified financing system with expenditure limits. A unified financing system will involve a partnership between the public and private sectors."

Steuerle, Gene.
How households pay for health care. Tax notes, v. 54, Mar. 9, 1992: 1287-1288.

"If health reform is ever to take place in this country, households will have to become much more educated about how the health market works. One reason that it is so difficult to reform this market, as well as to get health costs under control, is that households have been made ignorant of the costs of health care. They have almost no idea of how much they are paying indirectly through taxes, lower cash wages, and other means."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Commerce, Consumer Protection, and Competitiveness.
Rising cost of health insurance and U.S. competitiveness. Hearing, 102nd Congress, 2nd session. Feb. 5, 1992. Washington, G.P.O., 1992. 73 p.
"Serial no. 102-117"

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Rising cost of private health insurance. Hearing, 102nd Congress, 1st session. Apr. 30, 1991. Washington, G.P.O., 1991. 113 p.
"Serial no. 102-43"

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Rising cost of private health insurance: administrative expenses. Hearing, 102nd Congress, 2nd session. Feb. 20, 1992. Washington, G.P.O., 1992. 170 p.
"Serial no. 102-119"

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Oversight and Investigations.
Health care fraud and waste (Parts 1-2). Hearing, 102nd Congress, 1st and 2nd sessions. Oct. 10, 1991-Mar. 18, 1992. Washington, G.P.O., 1992. 2 v. (216, 109 p.)
Serial nos. 102-107 and 102-134.

U.S. Congress. House. Select Committee on Aging.
The high cost of prescription drugs. Hearing, 101st Congress, 2nd session, May 18, 1990. Washington, G.P.O., 1990. 48 p.
Hearing held in Baltimore, Maryland.
"Comm. pub. no. 101-769."

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Medicare and Medicaid budget priorities in the 1990's. Hearing, 101st Congress, 1st session. Mar. 23, 1989. Washington, G.P.O., 1989. 166 p.
"Comm. pub. no. 101-724"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Soaring health costs: why our medical bills are so high. Hearing, 102nd Congress, 2nd session. Aug. 31, 1992. Washington, G.P.O., 1993. 141 p.
Hearing held in Mount Laurel, N.J.
"Comm. pub. no. 102-906".
Identifies "medical liability insurance, excessive diffusion of technology, overdiagnosis and overtreatment of illnesses and conditions, labor and supply costs, administrative burdens, and consumer expectations" as driving factors contributing to increased costs.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
Health care fraud: protecting yourself from unfair sales practices. Hearing, 102nd Congress, 2nd session. Sept. 28, 1992. Washington, G.P.O., 1993. 77 p.
Hearing held in Fairview Heights, IL.
"Comm. pub. no. 102-907"

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Prescription drugs: is there a cure for the costs? Hearing, 102nd Congress, 2nd session. Jan. 16, 1992. Washington, G.P.O., 1993. 74 p.
Hearing held in Vancouver, Wash.
"Comm. pub. no. 102-901"

U.S. Congress. Joint Economic Committee.
Rising health care costs: are they really making it harder for U.S. firms to compete? Hearing, 101st Congress, 2nd session. May 23, 1990. Washington, G.P.O., 1990. 136 p. (Hearing, Senate, 101st Congress, 2nd session, S.Hrg. 101-900)

U.S. Congress. Joint Economic Committee. Subcommittee on Education and Health.
Health-care reform: how to push less paper and treat more patients. Hearings, 102nd Congress, 2nd session. Washington, G.P.O., 1992. 785 p. (Hearings, 102nd Congress, 2nd session, S. Hrg. 102-778)
Hearings head Oct. 2-Dec. 9, 1991.

U.S. Congress. Senate. Committee on Finance.
Comprehensive health care reform and cost containment. Hearings, 102nd Congress, 2nd session. May 6-June 18, 1992. Washington, G.P.O., 1992. Parts 1-2. 2 v. (442, 503 p.) (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-863, Pts. 1-2)

U.S. Congress. Senate. Committee on Finance. Subcommittee on Medicare and Long-Term Care.
Medical malpractice liability. Hearing, 102nd Congress, 1st session. Oct. 18, 1991. Washington, G.P.O., 1992. 231 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-542)

U.S. Congress. Senate. Select Committee on Aging.
The effects of escalating drug costs on the elderly. Hearing, 102nd Congress, 2nd session. Apr. 22, 1992. Washington, G.P.O., 1992. 113 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-787)
"Serial no. 102-21"
Hearings held in Macon and Atlanta, Ga.

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A status report: accessibility and affordability of prescription drugs for older Americans (includes a directory of pharmaceutical manufacturer indigent patient programs). Washington, G.P.O., 1992. 94 p. (Print, Senate, 102nd Congress, 2nd session, committee print, S. Prt. 102-100)
"Serial no. 102-O"
"Purpose of this report is to update the Congress and the American people about the impact of rising drug costs on older Americans, and analyse the extent to which

public and private insurance programs meet the need of providing drugs to this population group."

U.S. Congressional Budget Office.
Projections of National health expenditures. Washington, C.B.O., 1992.

U.S. General Accounting Office.
Health insurance: cost increases lead to coverage limitations and cost shifting; report to congressional requesters. May 22, 1990. Washington, G.A.O., 1990. 34 p.
"GAO/HRD-90-68, B-230452"
Discusses major health care cost-cutting measures being adopted by U.S. firms, including reduced benefits for employees, dependents, or retirees. "State-mandated benefits and state premium taxes fall primarily on the smaller firms, which are unable to self insure," as do many larger firms.

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Health insurance: vulnerable payers lose billions to fraud and abuse; report to the chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives. May 7, 1992. Washington, G.A.O., 1992. 34 p.
"GAO/HRD-92-69, B-246412"

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Medical malpractice: data on claims needed to evaluate health centers' insurance alternatives; report to the chairman, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate. May 2, 1991. Washington, G.A.O., 1991. 13 p.
"GAO/HRD-91-98, B-242811"
Considers the malpractice insurance burden for Bureau of Health Care Delivery and Assistance grant recipients who operate community and migrant health centers serving the disadvantaged.

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Medicare: millions in disabled beneficiary expenditures shifted to employers; report to congressional committees. Apr. 10, 1991. Washington, G.A.O., 1991. 42 p.
"GAO/HRD-91-24, B-239746"
Studies the cost savings to Medicare and the effects on employment and health insurance coverage of disabled beneficiaries since the Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for medical expenses incurred by certain disabled beneficiaries covered by large group health plans.

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U.S. health care spending: trends, contributing factors, and proposals for reform; report to the chairman, Committee on Ways and Means, House of Representatives. June 10, 1991. Washington, G.A.O., 1991. 19 p.
"GAO/HRD-91-102, B-243905"
Finds that some of business and governments' "piecemeal cost-containment strategies over the past decade . . . failed; others achieved limited success that restrained expenditures for only one payer (for example, a business or a state). This experience suggests that, if the United States is to slow the rapid pace of health care spending by all payers--public and private--the nation must develop a comprehensive strategy that affects the entire spectrum of health care payers and services."

U.S. Institute of Medicine. Committee on Utilization Management by Third Parties.
Controlling costs and changing patient care?: the role of utilization management. Washington, National Academy Press, 1989. 312 p.
Focuses on the private sector, and the effectiveness of this new system of bringing patient-level and system-level concerns together on cutting costs.

Waldo, Daniel R.
Financing health care: out of whose pocket? Quarterly review of economics and business, v. 30, winter 1990: 101-113.
"Health expenditures have grown steadily in the United States, but though United States spending is the highest in the world, it may be as far out of line as is often assumed. However, although the economy is capable of absorbing an increasing amount of health care without reducing other consumption, financing mechanisms are breaking down. That part of Medicare financed through payroll taxes will be insolvent

by the year 2003; the rest of Medicare and all of Medicaid adds to a growing budget deficit. And, the free market fails to provide rational long-term financing of long-term care."

Within, Gordon.
Health care fraud. U.S. news & world report, v. 112, Feb. 24, 1992: 34-38, 41-43.
Details health-care scams which "are growing dramatically bigger, bolder, and more sophisticated," as "up to $80 billion is stolen each year from taxpayers and insurers."

Zollinger, Terrell W.
A determination of institutional and patient factors affecting uncompensated hospital care. Hospital health services administration, v. 36, summer 1991: 243-256.
"The purpose of this article is to determine the effect of selected patient and hospital characteristics on the amount of variation in the amount of the hospital charge left unpaid. This information can be used to better establish strategies to minimize the amount of bad debt expense in our hospitals. While the hospital serves as an important source of care for the medically indigent, society needs to develop policies in order to provide adequate compensation to hospitals that deliver such care."

## B. OPTIONS FOR CONTROLLING COSTS

Aaron, Henry. Schwartz, William B.
Rationing health care: the choice before us. Science, v. 247, Jan. 26, 1990: 418-422.
"Rapid technological advances and upward pressure on wages of hospital personnel are leading to a steady increase in health care spending that is absorbing an ever-larger fraction of gross national product. Eliminating inefficiencies in the system can provide brief fiscal relief, but rationing of beneficial services, even to the well-insured, offers the only prospect for sustained reduction in the growth of health care spending. The United States, which has negligible direct experience with rationing, can learn about choices it will face from the experience of Great Britain where health care has been rationed explicitly for many years."

Aaron, Henry J. Schwartz, William B.
Managed competition: little cost containment without budget limits. Health affairs, special supplement 1993: 204-215.
"The right mix of these two approaches to cost control is still unkown and is likely to vary within the United States depending on local conditions. Therefore, the federal government should set targets for health care spending but leave considerable latitude to the states on how to meet those targets."

Altman, Stuart H. Cohen, Alan B.
The Need for a National global budget. Health affairs, special supplement 1993: 194-203.
"In this paper we first discuss why cost control is so critical to the long-term health of the American health care system. Next we outline the major issues and questions that must be addressed in designing and implementing global budgets (or expenditure limits). We conclude with a discussion of how expenditure limits may be used in concert with managed competition models to address the overriding cost issue."

Anderson, Gerard F.
All-payer ratesetting: down but not out. Health care financing, 1991 annual: 35-44.
"In the United States, when the cost-containment paradigm shifted from regulation to competion, all-payer hospital ratesetting went out of favor....author concludes that all-payer ratesetting is able to meet its multiple objectives of cost containment, reduction of the amount of cost shifting, improvement of access to the uninsured, and increased productivity. At the same time, all-payer ratesetting has not stifled the diffusion of any impact on length of stay, admissions, and quality of care is small, if it exists at all."

Back, Kelli D.
Rationing health care: naturally unjust? Hamline journal of public law and policy, v. 112, fall 1991: 245-257.

"The problems of escalating health care costs and declining access to health care services demand attention. Health care rationing is a mechanism that could address both. This paper serves to illustrate that rationing is a flexible tool and could be adjusted in some form to be used in the United States. Rationing is also a fairly radical step towards controlling our problems. A radical step may be needed. For those appalled by the thought of denying health care to those who need it, perhaps the threat of rationing will serve as an impetus to find other solutions."

Bacon, Jeremy.
Ambulatory health care: a growing concern. Business & health special report, 1991: 18-22.

"Successful efforts over the past few years to bring hospitalization costs under control have led to an increase in outpatient care, and to major increases in costs for such treatment."

Baker, Laurence C. Cantor, Joel C.
Physician statisfaction under managed care. Health affairs, special supplement 1993: 258-270.

"Overall, managed care does not seem to have had the deleterious impact on medical practice that was forecast for it."

Battagliola, Monica.
Labor makes strides in health care cost containment. Business & health, v. 10, Aug. 1992: 36, 40-41.

"An increasingly common situation . . . is one in which labor and management work together to contain health care costs. In instances where a level of trust has been attained, labor/management teams have joined ranks away from the bargaining table to pressure insurers to reduce premiums, tackle prescription drug costs, and find better ways to reduce utilization."

Baum, Laurie.
Health care under the knife. Business month, v. 134, Aug. 1989: 54-57.

"As medical costs swell, companies are looking for creative solutions. Seven savvy managers tell how they are whipping inflation now."

Berman, Howard J. Klein, David.
Pieces of the puzzle: steps toward affordable health care. Hospital & health services administration, v. 32, spring 1992: 3-11.

Recommends "changing the most commonly held health insurance product to a plan with high-deductible design, and reinstituting community-based health planning."

Betley, Charles.
The evolution of alternative health care delivery systems. Washington, Employee Benefit Research Institute, 1989. 15 p. (EBRI issue brief, no. 93)

Identifies alternative health care delivery systems, including managed care, HMOs, and PPOs. Discusses public policy issues.

Brenneman, David L.
New RX to cure health care cost increases. Pension world, v. 25, Nov. 1989: 12-14, 16.

Bryant, Meg.
The benefits of alternative care. Business & health, v. 9, Dec. 1991: 57-58, 60.

"Caring for patients in settings other than hospitals can lead to quicker recoveries and lower costs."

Butler, Stuart M.
Containing health costs in a consumer-based model. Health care financing review, 1991, suppl.: 21-25.

"The assumption that consumer choice cannot be used to achieve cost control in health care is invalid. It does not do so today because the tax treatment of health care leads to perverse consumer incentives that encourage cost escalation. By reforming the tax treatment of insurance and out-of-pocket medical costs, it is possible to design an efficient and universal system in which consumer choice is a powerful restraint on cost."

Callahan, Daniel.
Rationing medical progress: the way to affordable health care. New England journal of medicine, v. 322, June 21, 1990: 1810-1815.

Argues that "the demand for autonomy and choice, as well as for high-quality care, represents values that can be scaled back considerably without a serious loss in actual health . . . . There is a diminishing social return from attempts to make health care a source of expanding profit and personal enrichment." A companion article, "Age as a criterion for rationing health care," by Norman Levinsky, rejects the use of the elderly as a focus for proposals to ration care or to reduce costs.

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Symbols, rationality, and justice: rationing health care. American journal of law & medicine, v. 18, nos. 1-2, 1992: 1-13.

"Proposals to ration health care in the United States meet a number of objections, symbolic and literal. Nonetheless, an acceptance of the idea of rationing is a necessary first step toward universal health insurance. It must be understood that universal health care requires an acceptance of rationing, and that such an acceptance must precede enactment of a program, if it is to be economically sound and politically feasible. Commentators have argued that reform of the health care system should come before any effort to ration. On the contrary, rationing and reform cannot be separated. The former is the key to the latter, just as rationing is the key to universal health insurance."

Cotton, Paul.
Clinton tinkers with health system status quo.: critics seek to pick apart managed competition. JAMA [Journal of the American Medical Association], v. 269, Mar. 10, 1993: 1229-1230, 1232.

Reports Clinton's statements and the "mounting criticism" of managed competition as a currently-proposed reform plan.

Custer, William.
Rationing: resource allocation in the current health care delivery system. Washington, Employee Benefit Research Institute, 1992. 30 p. (EBRI issue brief, no. 131)

Explores "what differences exist in the utilization of health care services and who makes the decisions that create these differences. It finds that similar people are given different treatments as a result of decisions made by others." Since we thus already have some rationing, current debate "should focus on the mechanism for allocating health care resources and the tension between individual decision making and social objectives."

Davis, Michela.
Why global spending caps won't help the health care system. Washington, Citizens for a Sound Economy Foundation, 1993. 5 p.

Argues that "fixed health care spending caps are incompatible with quality care, competition and individual consumer choice." To control costs, "patients must evaluate services, at least in part, on the basis of price."

Dentzer, Susan.
Excessive claims: the health-care crisis. Business month, v. 135, July 1990: 52, 54-56, 58, 60, 63.

Finds that industries cannot manage their health care benefits to reduce costs; "The most discouraging news is that most of the cost-containment fads introduced in recent years have been a bust." Sees managed care as the strategy of the 1990s, while corporations continue to push for reforms in health insurance and health care.

Dixon, Lloyd. Hosek, Susan. Blake, Darlene.
Utilization and costs in the CHAMPUS Reform Initiative: preliminary results for April-September 1989. Santa Monica, Calif., Rand Corporation, 1991. 61 p. (A RAND Note. N-3243-HA)

"This Note presents interim results from an evaluation of the CHAMPUS Reform Initiative (CRI), which was implemented in August 1988 throughout California and Hawaii to demonstrate major reforms of the military health care system."

Economic implications of rising health care costs. Washington, Congressional Budget Office, 1992. 63 p.

Examines how the costs affect workers, employers, and Federal, State, and local governments. Reports on causes for rapid increases in costs and the inefficiencies of health care markets.

Ellwood, Paul M. Enthoven, Alain C. Etheredge, Lynn.

The Jackson Hole initiative for a twenty-first century American health care system. Health economics, v. 1, 1992: 149-68.

"This strategy requires far-reaching changes in the health system's information, institutions, incentives and regulation, as well as basic health insurance coverage for all citizens. It is a blueprint for both private and public sector actions."

Emanuel, Ezekiel.

The prescription: a primer on health care reform. New republic, v. 206, June 1, 1992: 21-22, 24, 26.

Sets forth rules for reform. "Any program to expand access to health care must be linked to cost control . . . . One-time cost savings schemes will not substitute for controlling health care inflation . . . . Cost controls mean containing inflation and limiting the use of technology . . . . An independent board should have authority to impose a national health care budget." Prefers a community-based voucher plan.

Enthoven, Alan C.

A Cure for health costs. World monitor, v. 5, Apr. 1992: 34, 36-39.

"The world's biggest economy pays too much for health care--and gets too little. A management expert offers this new blueprint for reform."

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The History and principles of managed competition. Health affairs, special supplement 1993: 24-64.

"Managed competition is based on comprehensive care organizations that integrate financing and delivery. Prospects for its success are based on the success and potential of a number of high-quality, cost-effective, organized systems of care already in existence, especially prepaid group practices. As it is outlined here, managed competition as a means to reform the U.S. health care system is compatible with Americans' preferences for pluralism, individual choice and responsibility, and universal coverage."

Faltermayer, Edmund.

Strong medicine for health costs. Fortune, v. 121, Apr. 23, 1990: 221, 224, 226, 228, 230.

"In Cigna's system, known as the open HMO, or point-of-service system, patients are also free to go outside the HMO whenever they need care. In that case, the plan still pays, but only 80 cents on the dollar and only after the year's expenses exceed a fairly stiff deductible. This feature attracts those who might otherwise reject being locked into a limited network of doctors and hospitals."

Fielding, Jonathan E. Rice, Thomas.

Can managed competition solve the problems of market failure? Health affairs, special supplement 1993: 216-228.

"This Commentary is not intended to provide a thorough evaluation of managed competition. Rather, it deals with the topic only insofar as managed competition can or cannot solve problems of market failure in the health care system. There are many other important aspects of managed competition, such as risk adjustment, whether managed competition can work in rural areas, and so forth, which we address only in passing."

Ginsburg, Paul B. Thorpe, Kenneth E.

Can all-payer rate setting and the competitive strategy coexist? Health affairs, v. 11, summer 1992: 73-86.

"In conclusion, we do not believe the nation has to choose between all-payer rate setting and the competitive strategy. The two are sufficiently compatible that both can be pursued, with the combination potentially a permanent one. The more successful competitive plans are, the smaller the portion of the health care system to which all-payer rate setting would apply.

Goodman, John C. Musgrave, Gerald L.

How to solve the health care crisis. Consumers' research, v. 75, Mar. 1992: 10-14, 35.

Recommends creation of individual or family "Medisave accounts." Asserts these would lower the cost of health insurance and the administrative and other costs of health care; would restore the doctor-patient relationship; would give patients more control over insured services; would enjoy advantages of a competitive medical marketplace, and would expand benefits of self insurance or options for health insurance during retirement.

Health care cost containment. By Karen Davis et al. Baltimore, Johns Hopkins University Press, 1990. 266 p. (Johns Hopkins studies in health care finance and administration; no. 3)

Health information systems. Hospitals, v. 67, Feb. 20, 1993: 26-29, 31-32, 36-38, 40.

Partial contents.--Holding networks together: shared information will glue for reformed health systems, by Kevin Lumsdon.--Military maneuvers: DoD moves ahead with integrated clinical records, by Terese Hudson.--Infrastructure is path to IS growth.--HELP on the way: clinical system lays framework for CPR.--The real thing: future information needs will require 'true' hospital CIOs, by Rob Hard.

Hoy, Elizabeth W.

Insurer-sponsored managed health care: 1990. Washington, Health Insurance Association of America, 1991. 26 p.

"The dynamic growth in managed care plans - and in the associated techniques for monitoring and evaluating care - manifests the industry's continued search for solutions to the problem or rising health care costs as well as its commitment to quality care for consumers."

Jencks, Stephen F. Schreber, George J.

Containing U.S. health care costs: what bullet to bite? Health care financing review, 1991 suppl.: 1-12.

"In this article, the authors provide an overview of the problem of health care cost containment. Both the growth of health care spending and its underlying causes are discussed. Further, the authors define cost containment, provide a framework for describing cost-containment strategies, and describe the major cost-containment strategies. Finally, the role of research in choosing such a strategy for the United States is examined."

Jones, Stanley B.

Multiple choice health insurance: the lessons and challenge to private insurers. Inquiry (San Francisco), v. 27, summer 1990: 161-166.

Discovers that "while group and staff model HMOs contain costs, few have cut employers' costs in multiple choice health plans, and group and staff model HMOs' capacity to contain costs has not been matched by insurers' managed care plans. Three options for insurers and HMOs to offer employers are outlined."

Kalb, Paul E.

Controlling health care costs by controlling technology: a private contractual approach. Yale law journal, v. 99, Mar. 1990: 1109-1126.

"This Note proposes a private sector cost-containment initiative that emphasizes controlling the use of medical technologies as a means of controlling health care costs and analyzes the legal implications of such an initiative."

Koska, Mary T.

Physician groups plan on being major factor in reform debate. Hospitals, v. 66, Aug. 20, 1992: 30, 32, 34.

Explains objections of the American Medical Association to the American Hospital Association's health care reform proposal, based primarily on its support for capitated payment to providers and emphasis on managed care. Reports plans being proposed by the American Society of Internal Medicine and by other State or specialty medical societies, as well as results of a survey of physician opinion on reform."

Kronick, Richard.

The marketplace in health care reform: the demographic limitations of managed competition. New England journal of medicine, v. 328, Jan. 14, 1993: 148-152.

"In sparsely populated areas where relatively few providers are required, . . . it is not feasible to divide the provider community into competing groups . . . . Demographic features of health markets in the United States [are examined] to see what proportion of the population lives in areas that might successfully support managed competition . . . . Smaller metropolitan areas and rural areas would require alternative forms of organisation and regulation of health care providers to improve quality and economy."

The Law and policy of health care rationing: models and accountability. University of Pennsylvania law review, v. 140, May 1992: whole issue (1505-2096 p.)
Explores "the concept of rationing amidst the pressing and contradictory problems presented by the large number of individuals without adequate health insurance and the rapidly rising costs of health care. While proposals to change our health care system are abundant, thorough analyses of the underlying issues are not, particularly among elected officials."

Long, Stephen H. Rodgers, Jack.
Perspective: managed competion estimates for policy making. Health affairs, special supplement 1993: 243-247.

Luthans, Fred. Davis, Elaine.
The healthcare cost crisis: causes and containment. Personnel, v. 67, Feb. 1990: 24-29, 31.
"As the healthcare cost crisis continues, HR professionals will take on a new role: being the watchdog for managed care. The performance of the managed care providers and the limitations that the company benefits structure imposes must be watched closely to prevent malpractice suits against the company. HR professionals may be charged with the difficult--if not impossible--task of balancing the need to reduce costs against the importance of providing quality care."

Managed care. Employee benefit plan review, v. 47, Mar. 1993: 56-60, 62-69.
"Begins with a look at various managed care vehicles--HMOs, preferred provider organizations, and point-of-service plans. The role of managed care in government-run health programs also is included, followed by the use of managed care for specific types of health benefits."

Managed care in the 1990s: providers' new role for innovative health delivery. Hospitals, v. 66, Mar. 20, 1992: 26-32, 34.
"Hospitals, physicians and employers are embracing fundamental managed care principles like utilization management. And these three parties are looking beyond such elementary devices to the next generation of managed care: integrating finance, administration and delivery."

Mendelson, Daniel N. Arnold, Judith.
Certificate of need revisited. Spectrum, v. 66, winter 1993: 36-44.
This regulatory review process requiring certain health care providers to obtain State authorization for major capital expenditures or service expansions is seen as potentially effective in "tracking and controlling the spread of facilities and services" in the future. Characteristics of successful State CON programs are identified.

Newhouse, Joseph P.
An Iconoclastic view of health cost containment. Health affairs, special supplement 1993: 152-171.
"Calls for medical care cost containment are all around us. . . . Effective global budgets would address the rising opportunity costs of health care. However, they would threaten ongoing innovation and probably would increase distortions from pricing errors."

O'Connor, Kathleen.
Risky business: HMOs and managed care. Business & health, v. 9, June 1991: 30, 32-34.
"Are HMOs doing all they can do to control health care costs? Or are they enjoying the best of both worlds; that is, healthy subscribers and 'equal dollars'?"

O'Keeffe, Janet E.
Health care financing: how much reform is needed? Issues in science and technology, v. 8, spring 1992: 42-49.
Decries that "President Bush's plan contains no meaningful systemwide measures to contain costs . . . . Any meaningful health care financing reform must address the

problems of the uninsured and the underinsured, and must include effective cost-containment strategies for the system as a whole."

One State's response to the malpractice insurance crisis: North Carolina's rural obstetrical care incentive program. Public health reports, v. 107, Sept.-Oct. 1992: 523-529.

"The program and how its implementation has maintained or increased access to obstetrical care in participating counties are described on the basis of site visits to local health departments in participating counties and data from the North Carolina Division of Maternal and Child Health. The program is of significance to policy makers nationwide as both a response to rising malpractice insurance rates and reduced access to obstetrical care in rural areas, and as an innovative, nontraditional State program in which the locus of decision making is at the county level."

Perspectives: design issues in managed competition. Health affairs, special supplement 1993: 87-137.

Contents.--Where should the buck stop: Federal and state responsibilities in health care financing reform, by Richard Kronick.--Benefit design choices under managed competition, by Linda A. Bergthold.--Safeguarding quality in managed competition, by Alan L. Hillman, William R. Greer, and Neil Goldfarb.--Challenges for managed competition from chronic illness, by Mark Schlesinger and David Mechanic.

Perspectives: health insurance purchasing cooperatives. Health affairs, special supplement 1993: 49-86.

Contents.--Who should govern the purchasing cooperatives? by Walter A. Zelman.--Design of health insurance purchasing cooperatives, by Paul Starr.--A Payment method for health insurance cooperatives, by James C. Robinson.--Informing and protecting consumers under managed competition, by Shoshanna Sofaer.

Reagan, Michael D.
Health care rationing and cost containment are not synonymous. Policy studies review, v. 9, winter 1990: 219-231.

"Much public discussion about health care assumes, explicitly or implicitly, that only by denial of potentially beneficial care (called 'rationing') can cost containment be achieved. This piece critically examines the various current usages of 'rationing,' and argues that it is being misapplied. Further, the call for rationing may be deflecting us from fruitful exploration of non-rationing alternatives to cost control. Two of these are briefly sketched as examples: physician fee controls and practice guidelines."

Reinhardt, Uwe E.
Reorganizing the financial flows in American health care. Health affairs, special supplement 1993: 172-193.

"This essay emphasizes the funneling of money into the insurance fund. It is argued *inter alia* that American business has been a quite unreliable partner in the financing of American health care and also a major cost driver. A reformed health system should reduce the role of business to the mere collection of premiums at the nexus of payroll."

Relman, Arnold B.
Controlling costs by "managed competition"--would it work? New England journal of medicine, v. 328, Jan. 14, 1993: 133-135.

"In the absence of some limit on total expenditures, how can we be sure it [managed competition] would save money in a system so driven by expansive entrepreneurial forces? . . . . No practical system of monitoring by public agencies could be expected to ferret out all the subtle ways in which managed-care organizations, controlled by third parties determined to show a profit, might stint on services." Urges putting "the responsibility for cost and quality control where it belongs--on physicians and their patients."

Rosko, Michael D.
All-payer rate-setting and the provision of hospital care to the uninsured: the New Jersey experience. Journal of health politics, policy and law, v. 15, winter 1990: 815-831.

"The New Jersey all-payer prospective payment compensates hospitals for charity care and bad debts. This study examines its impact on the provision of care to self-pay patients."

Rovner, Julie.

Doctor bills are next target for cost-control efforts. Congressional Quarterly weekly report, v. 47, Feb. 25, 1989: 386-392.

"Private sector may have to lead Congress in forcing major changes in fee-for-service system."

Saltford, Nancy.

Health promotion: its role in health care. Washington, Employee Benefit Research Institute, 1991. 8 p. (EBRI issue brief, no. 120)

"A healthy work force can mean lower workers' compensation, fewer claims for disability and health insurance, less turnover, reduced absenteeism, and increased productivity." Health promotion is urged for the public policy agenda to improve health and to reduce costs.

Sheils, John F. Lewin, Lawrence S. Haught, Randall A.

Potential public expenditures under managed competion. Health affairs, special supplement 1993: 229-242.

"The authors estimate a net increase of $47.9 billion in 1993 health spending under a managed competition program with low patient cost sharing. This includes savings of $4.5 billion from wider use of managed care and $11.2 billion in administrative cost savings."

Shoor, Rita.

Moving health care data electronically. Business & health, v. 10, Oct. 1992: 38, 40, 42-45.

"Pilot projects are experimenting with electronic data interchange and cutting the costs of administering claims in the process."

Simmons, Henry E. Rhoades, Margaret M. Goldberg, Mark A.

Comprehensive health care reform and managed competition: sounding board. New England journal of medicine, v. 327, Nov. 19, 1992: 1525-1528.

Describes the National Leadership Coalition for Health Care Reform's proposal "to create a public-private partnership" to improve the U.S. health care system.

Slomski, Anita J.

Groups dangle big salaries--but for how long. Medical economics, v. 88, Feb. 8, 1993: 45-47, 51-52, 54.

"Starting pay for primary-care doctors keeps climbing. With managed care and the Feds restricting reimbursement, though, the boom times may not last."

Smith, Lee.

A cure for what ails medical care. Fortune, v. 124, July 1, 1991: 44-49.

"Call it the American disease. The symptoms: unchecked health care spending and too many uninsured. The remedy: introducing more marketplace logic into the system."

Staines, Verdon S.

Potential impact of managed care on National health spending. Health affairs, special supplement 1993: 248-257.

"Illustrative estimates suggest that if all acute health care services were delivered through staff- or group-model health maintenance organizations (HMOs), national health spending might be almost 10 percent lower."

Starkey, Danielle.

Controlling costs and improving access--solving the health care dilemma. California journal, v. 24, Feb. 1993: 7-12.

Discusses Clinton Administration consideration of health care reform. "The Clinton plan is taking shape as a derivation of 'managed care,' a system that's been evolving for 50 years . . . . Managed competition, the strategy Clinton is eyeing, takes managed care one step further." Portrays options of increasing taxes, employer mandates, or rate ceilings to pay for health costs.

Starr, Paul.
The logic of health-care reform. Knoxville, Tenn., Grand Rounds Press, Whittle Direct Books, 1992. 83 p.
The author's "core proposal incorporates two fundamental concepts--global budgeting and managed competition--and focuses on the underlying structure of health care financing rather than single issues that are symptomatic of the current flawed system."

Starr, Paul. Zelman, Walter A.
A Bridge to compromise: competition under a budget. Health affairs, special supplement 1993: 1-23.
"A new approach to universal health insurance combining managed competition and global budgets promises to break the impasse blocking comprehensive health reform. The central innovation is the development of regional health insurance purchasing cooperatives (HIPCs) as manager and reorganizers of the market and platforms for global budgets. Financing would be based on community-rated premiums, with obligations to employers capped as a percentage of payroll and to individuals as a percentage of family income. Budgets would cap the mandated core of spending and set a target for out-of-pocket expenditures."

Stern, Linda.
Militant medicine. Business & health, v. 9, Oct. 1991: 70, 72, 74, 76, 78, 80.
"Early results are in, and if pleasing beneficiaries, saving dollars, and impressing third-party evaluators are any guide, the CHAMPUS Reform Initiative (CRI) is working well. Statistical results show a 4 percent decrease in health care costs compared with a 13 percent cost increase in areas without the program."

Steslicke, William E.
Florida's new health care cost containment board: "competition," "regulation," or what? Florida policy review, v. 4, winter 1989: 12-16.
"Not only has the HCCCB's role itself been rewritten by the State Legislature, but the name of the play seems to have been changed from 'Competition' to 'Regulation.'"

Steurle, C. Eugene.
The search for adaptable health policy through finanace-based reform. In American Health Policy: Critical Issues for Reform, edited by Robert B. Helms. Washington, American Enterprise Institute, 1993. p. 334-361.

Stevens, Carl M.
Health care cost containment: some implications of global budgets. Science, v. 259, Jan. 1, 1993: 16-17, 105.
Warns that in the U.S. "there has been some serious discussion, and some implementation, of partial expenditure caps, notably for the big federal government health insurance programs Medicare and Medicaid." Discusses "problems in reflecting or representing consumer preferences in the decisions that allocate resources for health care, and implications for providers and consumers (patients) of the non-price rationing necessarily accompanying the imposition of effective expenditure caps."

Tadjer, Rivka.
Can case management cut costs? Life association news, v. 85, Jan. 1990: 63-67.

Tanner, Michael.
Health care reform: the good, the bad, and the ugly. Washington, Cato Institute, 1992. 29 p. (Policy analysis no. 184)
After analyzing a variety of current proposals, including single-payer plans, "Play or pay" options, and managed competition, the author recommends tax-deductible medical IRAs, which "would return choices about health care expenditures to consumers, giving them incentives to shop effectively, cut costs, and accumulate unused funds tax free for retirement."

Taulbee, Pamela.
Employers are experimenting with managed competition. Business & health, v. 10, Mar. 1992: 26-28, 30, 32, 34, 38.
"'Managed competition requires that the employer assess the HMOs it chooses for quality and cost effectiveness and then hold them accountable for those qualities'."

U.S. Congress. House. Committee on the Budget. Republican Staff.
A managed competition: remedy for U.S. health care? Budget and economic analysis, v. 2, Dec. 21, 1992: 1-4.

Available from the House Budget Committee Republican Staff.

Protests that, although "managed competition constitutes a significant advance in the debate on health care reform," "the regulatory/health planning strategy, of which global health budgets are one tool, is likely to deflect attention from the underlying causes of our health care cost problem, . . . lack flexibility in responding to future needs, [and] . . . reduce the quality of U.S. health care and substitute waiting lines and increased pain and suffering, and even premature death for dollar expenditures."

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Options for health insurance: requirements for health care cost containment. Hearing, 102nd Congress, 1st session. July 11, 1991. Washington, G.P.O., 1992. 144 p.
"Serial 102-48"

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Options for health insurance: using Medicare payment methodologies as the basis for establishing rates for hospital and physician services for all payers. Hearing, 102nd Congress, 2nd session. Apr. 8, 1992. Washington, G.P.O., 1992. 157 p.
"Serial 102-106"

Health care providers, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, and CBO testify.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Medicare and Long-Term Care.
Reducing inappropriate Medicare spending. Hearing, 102nd Congress, 2nd session, May 21, 1992. Washington, for sale by the U.S. G.P.O., Supt. of Docs., Congressional Sales Office, 1992. 113 p. (U.S. Congress. Senate. S. hrg. 102-889)

U.S. Congress. Senate. Committee on Labor and Human Resources.
Achieving effective cost control in comprehensive health care reform. Hearings, 102nd Congress, 2nd session. Dec. 16-17, 1992. Washington, G.P.O., 1992. 306 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-955)

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Health Insurance Purchasing Cooperative Act. Hearing, 102nd Congress, 2nd session. May 7, 1992. Washington, G.P.O., 1992. 90 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-630)

"To promote the use of State-coordinated health insurance buying programs and assist States in establishing health insurance purchasing cooperatives, through which small employers may purchase health insurance, and for other purposes.

U.S. Congressional Budget Office.
The potential impact of certain forms of managed care on health care expenditures. Washington, Congressional Budget Office, 1992. 31 p. (CBO staff memorandum)

"Presents a range of illustrative estimates of the potential effects on national health expenditures and on expenditures under Medicare, Medicaid, and private health insurance if all acute health care services that are now funded through insurance arrangements were provided through delivery systems incorporating two specific forms of managed care. One is staff-model and group-model health maintenance organizations. The other is 'effective' forms of utilization review, which . . . incorporates precertification and concurrent review of inpatient care."

U.S. Institute of Medicine. Committee on Utilization Management by Third Parties.
Controlling costs and changing patient care?: the role of utilization management. Washington, National Academy Press, 1989. 312 p.

Focuses on the private sector, and the effectiveness of this new system of bringing patient-level and system-level concerns together on cutting costs.

Wallack, Stanley S.
Managed care: practice, pitfalls, and potential. Health care financing review, 1991, suppl.: 27-34.

"The results of coordinating and changing patterns of health care using managed care activities and organizations are reviewed in this article. Although utilization review and high-cost case management programs reduce the use of expensive services, incentives for providers of care, placing them at risk, are important for managing the

intensity of health care. Managed care appears capable of reducing health care costs substantially. However, this increased efficiency has not translated to lower insurance premiums or modulated total health care expenditures because either purchasers are not aware or are not concerned about securing care at the least cost."

Welch, W. Pete.
Giving physicians incentives to contain costs under Medicaid. Health care financing review, v. 12, winter 1990: 103-112.
"In this article, the risk arrangements in Medicaid programs that put physicians at risk are summarized. These programs--partial capitation and health insuring organizations--pay physicians a capitation amount to cover some or all physician services. Physicians also receive part of the savings from reduced hospitalization. Most of these programs have successfully lowered Medicaid costs. They could serve as models for other Medicaid programs, State-level programs to cover people ineligible for Medicaid, and programs abroad, such as in the United Kingdom."

Williams, Albert P.
Memorandum to the President-elect: parameters for health system reform. JAMA [Journal of the American Medical Association, v. 268, Nov. 18, 1992: 2699-2700.
Presents the chairman's interpretation of the consensus reached at the RAND Summer Institute, "Reforming the US Health Care System," July 27-31, 1992. Summarizes that "cost control is key to reforming the system, because universal coverage seems certain to be held hostage to a credible promise that cost can be contained. However, effective reform cannot occur without some increase in taxes or other levies for those who either are not paying their share of costs now or are benefiting from excessive tax relief."

Zwanziger, Jack.
Prospective payment for CHAMPUS exempt services: an analysis of children's hospitals, substance abuse services, and psychiatric services. Santa Monica, Calif., Rand Corp., 1992. 105 p. (Rand/R-3700-HA)

## IV. RESOLVED: THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE CATASTROPHIC HEALTH INSURANCE TO ALL UNITED STATES CITIZENS

### A. GENERAL

Aging in America: the Federal Government's role. Washington, Congressional Quarterly Inc., 1989. 95 p.

Contents.--The elderly.--Social security.--Medicare and medicaid.-- Catastrophic costs.--Long-term care.

Banham, Russ.

Insurance: a policy for catastrophe. Global fianance, v. 6, July 1992: 68-69.

Beyond Medicare. Consumer reports, v. 54, June 1989: 375-391.

Contents.--What insurance do you need?--Which policies are best?--What an insurance package costs.--The top-rated plans: where they are sold.--The insurance hard sell.--Deceptive sales tactics.

Brock, Horace W.

Rx for the U.S. health care crisis. Financial executive, v. 8, Jan.-Feb. 1992: 10-13.

Cotton, P.

"Pre-existing conditions 'hold Americans hostage' to employers and insurance." JAMA [Journal of the American Medical Association], v. 265, 1991: 2451-2453.

Coughlin, Teresa A. Liu, Korbin.

Severely disabled elderly persons with financially catastrophic health care expense: sources and determinants. Gerontologist, v. 32, June 1992: 391-403.

"This article describes the sources of financially catastrophic health care expenses among disabled elderly persons. Using a cost-to-income approach and data from the 1981-1982 Channeling Demonstration Project, we examined the types of health care costs (hospital, physician and ancillary care, nursing home, and prescription medicine) that contributed to overall expenses. For the Channeling sample, out-of-pocket expenses for prescription medicines and for nursing home care were the principle source of catastrophic expenses."

Cox, Hank.

Age before beauty. Regardie's, v. 11, Jan. 1991: 69, 71-79.

"The American Association of Retired Persons may be the only lobby in Washington with enough clout to bulldoze a massive new benefit program through Congress, only to have its own members force the repeal of the program less than a year later, and not experience so much as a twinge of embarrassment or offer a hint of an apology."

Del Bene, Linda. Vaughan, Denton R.

Income, assets, and health insurance: economic resources for meeting acute health care needs of the aged. Social security bulletin, v. 55, spring 1992: 3-25.

"In this article, the authors use data from the Survey of Income and Program Participation (SIPP) to examine the relationship between economic resources and acute health care needs among the aged. The circumstances of individuals who rely on Medicare as their only form of health insurance are considered in detail because they are potentially more vulnerable when faced with health care expenses. Particular attention is given to the amount of family income and personal contingency assets held by this group and the level of out-of-pocket liability for acute care they might have been expected to face in 1984."

Elwood, Thomas W.

A view from Washington. Journal of allied health, v. 19, winter 1990: 69-80.

"Many older persons display a strong sense of independence, and expect others to feel the same way. They resent the notion of receiving something for nothing. Their perception that their insurance premiums would be used to provide Medicare benefits for AIDS patients and welfare mothers was too unsettling. Advocates of the catastrophic legislaton should, perhaps, have paid more attention to the wisdom of developing a program that was not a blend of insurance and general entitlement concepts. Having adopted such a course, it is critical to do an adequate job of explaining what such a mixture entails. Those who pursue any similar idea in the future are suitably forewarned."

Estes, Carroll L.
Aging, health, and social policy: crisis and crossroads. Journal of aging & social policy, v. 1, 1989: 17-32.

"In the 1980s, significant and growing problems of uninsurance and underinsurance for health care have re-emerged. Simultaneously, state Medicaid programs are characterized by their increasing variation and inequities, while there has been a decline in access for the poor. The future of aging policy will be decided in the context of four socio-demographic realities: (1) population aging (2) trends in mortality and morbidity (3) the relationship between income and health, and (4) aging as a woman's issue."

Federa, R. Danielle. Oettinger, Nancy L.
Beyong catastrophic insurance: the future of public funding for long-term care. Topics in health care financing, v. 17, summer 1991: 22-31.

Green, Jesse. Arno, Peter S.
AIDS: the cost and financing of care. Caring, v. 8, Nov. 1989: 14-17.

"While the costs of caring for people with AIDS are high enough to be far beyond the means of most of those who have the illness, these costs are not beyond the means of society, since they constitute a small proportion of the health care budget. The difficulty is that the mechanisms society uses to assist individuals with unaffordable medical bills do not always work well. In the case of AIDS, these problems are greatly exacerbated by the fact that so many PWAs [people with AIDS] are young males in poverty. This is the group with the poorest access to insurance and to health care."

Hook, Janet.
Catastrophic insurance for all. Washington monthly, v. 19, Feb. 1987: 37-40.

Examines the arguments against providing catastrophic health insurance.

Iglehart, John K.
The American health care system: Medicare. New England journal of medicine, v. 327, Nov. 12, 1992: 1467-1472.

This fourth report on American health care discusses the history, financing, benefits, payment system, quality, and future of the program. "Providers are scarcely prepared to be the sole stakeholders who accept sacrifice. The only other real options are raising taxes on the general population, reducing Medicare benefits, or asking the elderly to pay more on some income-related basis."

Lammers, William W. Leiebig, Phoebe S.
State health policies, federalism, and the elderly. Publius, v. 20, summer 1990: 131-148.

"This article examines recent state health policy efforts for the elderly and their implications for future federal and state roles. States have been particularly active in creating programs to address the needs of the chronically ill and in seeking to modify regulatory policies and promote private sector efforts. Those efforts have involved relatively autonomous state programs as well as programs developed within the intergovernmental system. To meet the health policy needs of an increasing elderly population, future federal policies must recognize potentials for significant state contributions and seek to minimize actions that reduce policy innovation, while continuing to address the problem of limited responses in low-performance states."

Light, Donald W.
Excluding more, covering less: the health insurance industry in the U.S. Health/PAC bulletin, v. 22, spring 1992: 7-13.

"Through various devices used to avoid insuring high-risk individuals or paying out on claims, the insurance industry has instituted a spiral of exclusion and discrimination, so that those who need coverage most are likely to get the least and pay the most for what they get. Because these practices are inherent in competitive private insurance, it seems that as long as private health insurance companies are permitted to exist, universal health insurance is unlikely to succeed."

Lowry, Jack W.
How to keep health premiums down. Life association news, v. 85, Jan. 1990: 57-60.

Manning, Willard G. Marquis, M. Susan.
Health insurance: the trade-off between risk pooling and moral hazard. Report no. R-3729-NCHSR, Santa Monica, Calif., the Rand Corporation, 1989.

Monfils, Greg.
What Clinton could learn from the catastrophic health care catastrophe. Washington monthly, v. 25, Mar. 1993: 39-41.

"The catastrophic care bill's tortured collapse can provide the new administration with a road map of exactly what to avoid in tackling the tougher task of overhauling the entire health care system. On the universal list of Good Ideas That Bombed, the catastrophic care act ranks near the top." The author urges Clinton to use "his presidential bully pulpit to emphasize the need for doctors, hospitals and insurers to make a legitimate sacrifice in income so that the nation is not bankrupted by health care costs."

Preventive health services for Medicare beneficiaries: policy and research issues.
Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1990. 37 p. ("OTA-H-416, Feb. 1990")

In this special report, "OTA examines how decisions are currently made about coverage of specific preventive services under Medicare and lays out options for altering the process and criteria governing those decisions. The Special Report also reviews and critiques ongoing demonstration projects and summarizes the results of OTA studies of the costs and effectiveness of specific preventive services for the elderly."

Restructuring health insurance for Medicare enrollees. Washington, Congressional Budget Office, 1991. 74 p.

"A CBO study"

Partial contents.--Supplements.--Enrollees' out-of-pocket and premium expenses for acute health care.--Establish a Medicare copayment cap and prohibit Medigap coverage of Medicare's copayment requirements.--Restructure and cap Medicare's copayment requirements and prohibit Medigap coverage of them.

Rice, Thomas. Gabel, Jon.
Older Americans and their health coverage. Washington, Health Insurance Association of America, 1989. 27 p.

"Survey results indicate that despite the extensive publicity, the elderly still know very little about the basic aspects of the catastrophic legislation."

Short, Pamela Farley. Vistnes, Jessica Primoff.
Multiple sources of Medicare supplementary insurance. Inquiry, v. 29, spring 1992: 33-43.

"Estimates from the National Medical Expenditure Survey imply that in 1987 only two-thirds of elderly Medicare beneficiaries held the amount and type of insurance that is generally recommended to supplement Medicare, namely, 57.7% with private hospital medical insurance from one source and 6.6% with only Medicaid . . . . Beneficiaries who purchase coverage from more than one sources are likely to be relatively young, more highly educated, and financially better off."

Trippler, Aaron K.
Comprehensive health insurance for high risk individuals: a State-by-State analysis. Minneapolis, Communicating for Agriculture, 1986. 161 p.

Surveys "legislation creating a health insurance risk-sharing pool for individuals who find difficulty in purchasing adequate health insurance coverage due to pre-existing health conditions." Concludes that "risk pools represent a small step in reducing the uninsured population, or at least that segment of the uninsured that is not poor but could become poor when faced with major medical expenses. These plans, however, provide no comprehensive solution to the indigent care problem. Risk pools simply encourage and assist individuals in purchasing health insurance. Those who cannot afford to purchase insurance will in most cases not benefit from the pools."

U.S. Congress. House. Select Committee on Aging.
America's uninsured and underinsured: a nation at risk of inadequate health care and catastrophic costs; report. Washington, G.P.O., 1986. 13 p.

At head of title: Committee print.

"Comm. pub. no. 99-583"

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The catastrophe of uninsured and underinsured Americans: in search of a U.S. health plan. Hearing, 99th Congress, 2nd session. Sept. 12, 1986. Washington, G.P.O., 1986. 130 p.

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Health care needs of the elderly. Hearing, 101st Congress, 1st session. Washington, G.P.O., 1989. 79 p.
Hearing held July 31, 1989, Union, NJ.
"Comm. pub. no. 101-726"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Catastrophic health insurance: the needs of children. Joint hearing before the Subcommittee on Health and Long-term Care of the Select Committee on Aging and the Select Committee on Children, Youth, and Families, House of Representatives, 100th Congress, 1st session. Mar. 23, 1987. Washington, G.P.O., 1987. 293 p.
"Aging Committee pub. no. 100-629"
Includes statistical information in the testimony of James Perrin on behalf of the American Academy of Pediatrics (p. 61-74).

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Catastrophic health insurance: the New Jersey perspective. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 38 p.
"Comm. pub. no. 99-593"
Hearing held Aug. 11, 1986, Bellmawr, NJ.

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Catastrophic health insurance: the New Jersey and New York perspective. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 70 p.
Hearing held May 11, 1987, Newark, NJ.
"Comm. pub. no. 100-630"

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Catastrophic health insurance: the Pennsylvania perspective. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 41 p.
Hearing held Apr. 10, 1987, Philadelphia, PA.
"Comm. pub. no. 100-624"

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Catastrophic health insurance: the home care benefit. Hearing, 99th Congress, 2nd session. Mar. 19, 1986. Washington, G.P.O., 1986. 96 p.
"Comm. pub. no. 99-562"

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National health care: the financial impact on seniors and their families: a briefing by the Subcommittee on Health and Long-Term Care and the Select Committee on Aging, House of Representatives, 102nd Congress, 1st session. May 28, 1991. Washington, G.P.O., 1991. 133 p.
At head of title: Committee print.
"Comm. pub. no. 102-820"
The Committee met in Toms River, N.J. "Printed for informational purposes only. It does not represent either findings or recommendations adopted by this committee." Includes the American Nurses Association's "Nursing Agenda for Health Care Reform."

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Paying the price of catastrophic illness: from accidents to Alzheimer's. Hearing, 100th Congress, 1st session. Jan. 28, 1987. Washington, G.P.O., 1987. 176 p.
"Comm. pub. no. 100-616"

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Paying the price of catastrophic illness: from accidents to Alzheimer's. Washington, G.P.O., 1987. 58 p.
At head of title: Committee print.
"Comm. pub. no. 100-612"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
The future of health care for seniors: where do we go from here? Hearing, 101st Congress, 1st session. Dec. 4, 1989. Washington, G.P.O., 1990. 76 p.
"Comm. pub. no. 101-753"
Hearing held in Vancouver, WA.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Investigation on ways of minimizing routine and catastrophic health costs for the aging. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 111 p.
Hearing held in Essex, Md., Apr. 21, 1986.
"Comm. pub. no. 99-575"

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Nationalised health insurance: the lessons of catastrophic care. Hearing, 102nd Congress, 2nd session. Apr. 13, 1992. Washington, G.P.O., 1992. 82 p.
Hearing held in Waterbury, CT.
Comm. pub. no. 102-862"

U.S. Congress. Senate. Committee on the Budget.
Catastrophic and long-term health care. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1988. 955 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-586)
Hearings held June 1, 1987--Warren, MI; June 22--Flint, MI; June 29--Lansing, MI; Aug. 28--Marquette, MI; Nov. 11--Detroit, MI.

U.S. Congressional Budget Office.
Catastrophic medical expenses: patterns in the non-elderly, non-poor population. Washington, 1982. 108 p.
Partial contents.--Family medical expenses in a single year.--Patterns of high-cost illness over two or more years.--Trends in expenditures for high-cost illness. --Implications for Federal policy.

U.S. General Accounting Office.
Trauma care: lifesaving system threatened by unreimbursed costs and other factors; report to the Chairman, Subcommitee on Health for Families and the Uninsured, Committee on Finance, U.S. Senate. May 17, 1991. Washington, G.A.O., 1991. 44 p.
"GAO/HRD-91-57, B-242551"
"Provides information on the reasons hospitals in major urban areas withdrew from trauma care systems that serve people with life-threatening injuries."

Wasilewski, Charles.
Mature customers, immature products. Best's review: life/health/insurance edition, v. 87, Apr. 1987: 40-42, 44, 46.
Overviews the adequacy of and need for health insurance products which cover home care services, adult day care, nursing home care, long-term care services, and catastrophic illness. Offers the perspectives of the insurance industry, Congress, the Reagan Administration, and advocacy groups for the aged.

Where coverage ends: catastrophic illness and long-term health care costs. Washington, Employee Benefit Research Institute, 1988. 274 p. (EBRI-ERF policy forum)
Concludes that "many millions of Americans face possible financial ruin from uninsured health care expenses that are potentially catastrophic in nature. What is not clear is whose responsibility it is to pay these expenses."

Wise, Daniel.
Rainy-day plan. New York, v. 22, Dec. 4, 1989: 121-122, 124, 126, 129-132, 135-136, 138.
Describes the situations in which "the real catastrophe threatening the elderly isn't grave illness but the crushing cost of routine care."

## B. MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Brazda, Jerome F.

Catastrophic insurance law hammered out too hastily. Modern healthcare, v. 19, Aug. 25, 1989: 60.

Brody, Stanley J.
Strategic planning: the catastrophic approach. Gerontologist, v. 27, Apr. 1987: 131-138.

"Three major societal responses to the perceptions of catastrophe for the aging family are traced. The first two, the needs for basic subsistence and for access to acute care medicine, were resolved .... The third and unresolved catastrophe, the need for continuity of care, is defined, popular perceptions of that need evaluated, and a policy solution suggested."

Burke, Karen A.
Catastrophic health care kit. Washington, Republican Study Committee, 1987. 6 p.

"Designed to help Members determine what their elderly constituents think about H.R. 2470/2941 [Medicare Catastrophic Protection Act of 1987], and how they might want their Member to vote should the President veto the bill."

Catastrophic health insurance bill enacted. CQ almanac, 1988: 281-292.

Catastrophic health insurance for the elderly: a guide to the 1988 law. Report prepared by OMB Watch, Washington; Boston, Mass., Gerontology Institute, College of Public and Community Service, University of Massachusetts at Boston, 1988. 29 p.

Catastrophic insurance. Perspectives, Apr. 21, 1986: whole issue (4 p.)

Concludes that "public debate may generate political support for catastrophic health insurance, but changes in the American health system will be limited. Comprehensive health plans that increase government spending face an uncertain future."

Cohn, Jeffrey P.
Cancelling catastrophic health. Government executive, v. 21, Dec. 1989: 34-37.

Explains the extensive planning of setting up and then shutting down implementation of the legislated and then overturned prescription drug system.

Coster, John M.
Politics, Congress, and outpatient prescription drug coverage under Medicare: a historical review, 1965-1989. Pharmacy in history, v. 32, no. 3, 1990: 111-127.

Reviews the legislative history "of the major attempts made by Congress to add outpatient prescription drug coverage to Medicare both during and after the enactment of the original Medicare program."

Dentzer, Susan.
Rx for rising costs: Medicare's high-tech prescription for drug bills. U.S. news & world report, v. 107, Sept. 1, 1989: 50-51, 53.

Diamond, Joseph.
NAIC [National Association of Insurance Commissioners] moves to prevent medigap abuses. National underwriter (property/casualty/employee benefits), v. 93, Dec. 18, 1989: 10-11.

Donlan, Thomas G.
Just what the doctor ordered? Catastrophic health insurance: the benefits and the cost. Barron's, v. 68, Mar. 7, 1988: 13, 48-53.

Asserts that the legislation "is a classic example of the two-steps-forward, one-step-back school of legislating .... It's an equally classic example of budget gimmickry, ... of a legislative pig in a poke, .... [and] of promising more than could be delivered."

Dopkeen, Jonathan. Rappaport, Anna. Bergthold, Linda.
Crisis or opportunity? Business and health, v. 6, Nov. 1988: 24-29.

The Medicare Catastrophic Care Act of 1988 "presents an opportunity for employers to think through and redesign retiree medical plans that wrap around Medicare at a time when the future of these plans is under intense discussion. This redesign could take the form of cash as well as service benefits, long-term care as well as acute services, and even flexibile benefits."

England, Robert S.
The catastrophic health care blunder. American spectator, v. 21, Nov. 1988: 25-28, 30.
"The story of how Ronald Reagan, Otis Bowen [Health and Human Services secretary], and a rogue Congress came up with what might be the most expensive piece of social legislation since the Great Society--and still failed to provide real catastrophic care for our elderly."

Ferrara, Peter J.
Catastrophic health benefits translate into catastrophic taxes. Consumer research, v. 72, Apr. 1989: 11-14.
"Last year, Congress expanded Medicare to provide new catastrophic benefits covering high medical costs for the elderly. At the time, politicians scrambled to take credit for the new benefits. The cost of the program to the elderly was never mentioned. But now the elderly are discovering that the legislation also included stiff new taxes on them which are already mounting to a heavy financial burden."

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Controlling catastrophic health costs: Otis Bowen's grand opportunity. Washington, Heritage Foundation, 1986. 11 p. (Backgrounder no. 499)
Argues that "the catastrophic insurance study now underway is a key test for Otis Bowen. The Medicare expansion plan being urged by some of Bowen's staff contradicts Ronald Reagan's overall philosophy of greater reliance on the private sector."

Ferrara, Peter J. Butler, Stuart.
Making catastrophic health care affordable: a nine point program. Washington, Heritage Foundation, 1987. 13 p. (Backgrounder no. 563)
Describes a nine point program that would include changing "the law governing private policies supplementing Medicare to require insurance companies marketing policies to provide catastrophic hospital coverage," providing "vouchers through Medicare to assist the elderly to purchase private catastrophic insurance policies," and establishing "'Health Banks' to encourage workers to obtain inexpensive catastrophic coverage and save for their out-of-pocket health care costs."

Friedman, Bernard S. Ross, Caroline.
Catastrophic health insurance. National journal, v. 15, May 21, 1983: 1091-1093.
"During the last decade, legislative proposals for health insurance expansion have become much more modest--with emphasis now on catastrophic caps and concern for narrow groups of uninsured and/or lower income persons who do not now qualify for Medicaid . . . . Suggest[s] that experience with the state CHIPs indicates that such a non-categorical approach is feasible at modest cost without heavy regulation."

Fuchs, Beth C. Hoadley, John F.
Reflections from inside the Beltway: how Congress and the President grapple with health policy. PS, v. 20, spring 1987: 212-220.
Presents "an account of how one issue--catastrophic health insurance--reached the political agenda and then more general comments on how health legislation has been considered and passed in recent years, with particular emphasis on the use of the budget reconciliation process."

Haas, Lawrence J.
Fiscal catastrophe. National journal, v. 21, Oct. 7, 1989: 2453-2456.
"Although policymakers will almost certainly continue to use the pay-as-you-go method, if for no other reason than their desire to control the deficit, they may prove less eager to employ the kind of progressive user fee contained in the catastrophic care plan" after the recent "revolt" against the Medicare Catastrophic Coverage Act.

Hess, John L.
The catastrophic health care fiasco. Nation, v. 250, May 21, 1990: 698-702.
"Under catastrophic Medicare the elderly found themselves singled out to be taxed, ostensibly to relieve the plight of a relatively few old hospital patients. (Ordinary nursing-home care, the most serious financial problem for the elderly, was not covered by the program.) The act was striking departure from long-established principle, as if school taxes were to be levied only on parents. When the nature of the act seeped through the media smokescreen, a revolt scorched the grass roots."

Iglehart, John K.

Medicare's new benefits: 'catastrophic' health insurance. New England journal of medicine, v. 320, Feb. 2, 1989: 329-336.

Reviews the history and coverage of the Medicare Catastrophic Coverage Act.

Jackson, Wendy.

Catastrophic health care coverage bill: Medicare beneficiaries be alert! Employee benefits journal, v. 13, Sept. 1988: 26-28.

"Whether the Catastrophic Health Care Coverage Bill does more harm than good remains to be seen. Its designers have good intentions--to provide some federal aid to Medicare beneficiaries so that, when a catastrophic illness or condition occurs, their total savings will not be depleted."

Kosterlitz, Julie.

Bowen's quiet strength. National journal, v. 19, Feb. 7, 1987: 308-312.

Profiles "Health and Human Services Secretary Bowen [who] has drawn praise from Democrats and fury from the right; but he has put catastrophic health on the agenda." Contrasts his style with that of predecessor Margaret Heckler.

Long, Stephen H. Gordon, Nancy M.

Updated estimates of Medicare's catastrophic drug insurance program: a special study. Washington, Congressional Budget Office, 1989. 64 p.

Reports on the methodology used for projections of costs to Medicare of covering outpatient prescription drugs under the Medicare Catastrophic Coverage Act, comparing those estimates transmitted to Congress in July 1989 to earlier estimates. Does not consider options for modifying or eliminating the program.

Martin, Sara.

The Medicare drug benefit: challenges for pharmacists. American pharmacy, no. 7, July 1989: 22-25.

Analyzes drug-utilization review, and the coverage of prescribed medications specified in the 1988 Medicare Catastrophic Coverage Act.

Melbinger, Michael S. O'Donnell, Timothy.

The Medicare Catastrophic Coverage Act of 1988 and its impact on employer-sponsored retiree medical plans. Employee relations law journal, v. 14, winter 1988: 399-406.

"The Medicare Catastrophic Coverage Act of 1988 (MCCA) significantly enlarges the scope of federally funded health care benefits for elderly Americans. Since Medicare's inception in 1965, several inadequacies have become apparent, especially the absence of coverage for catastrophic illnesses. Now MCCA inhibits the potenital financial ruin of elderly Americans faced with overwhelming, extended medical costs. The Act is budget-neutral and can reduce employers' Social Security payroll tax costs."

Moon, Marilyn.

The Rise and fall of the Medicare Catastrophic Coverage Act. National tax journal, v. 43, Sept. 1990: 371-381.

"In this paper I lay out the basic chronology of the legislation and then discuss some of the lessons to be learned from this experience."

Rice, Thomas. Desmond, Katherine. Gabel, Jon.

The Medicare Catastrophic Coverage Act: a post-mortem. Health affairs, v. 9, fall 1990: 75-81.

Rovner, Julie.

Catastrophic-costs dilemma grips Ways and Means. Congressional Quarterly weekly report, v. 47, July 22, 1989: 1859-1861.

Reports on controversies surrounding revision of the catastrophic health insurance law.

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Catastrophic-costs measure back on track despite delays. Congressional Quarterly weekly report, v. 45, Oct. 31, 1987: 2677-2682.

Describes major provisions and compromises being discussed for catastrophic health costs legislation.

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Catastrophic-costs proposal pleases almost no one. Congressional Quarterly weekly report, v. 47, July 29, 1989: 1956-1959.

Summarizes the close compromise proposal approved by the House Ways and Means Committee on revision of the catastrophic health insurance law and premiums.

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Catastrophic-coverage law is dismantled by Congress. Congressional Quarterly weekly report, v. 47, Nov. 25, 1989: 3238-3239.

Summarizes the complaints of senior citizens which led to the repeal of the "largest expansion of Medicare since the program began in 1965." Lists "what's gone, what's left" of the Medicare Catastrophic Coverage Act.

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Catastrophic-coverage law narrowly survives test. Congressional Quarterly weekly report, v. 47, June 10, 1989: 1400-1402.

Reports on Senate debate on making changes to the new Medicare catastrophic insurance program.

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Climbing medigap premiums draw attention on Hill. Congressional Quarterly weekly report, v. 48, Feb. 17, 1990: 527-531.

"Nothing gets the attention of Congress faster than unhappy senior citizens. In 1989, a surtax of up to $800 per year for Medicare catastrophic coverage got the over-65 crowd so upset Congress finally repealed the program. In 1990, the resulting premium increases for private insurance to supplement Medicare may prompt a similar outcry. That possibility is focusing congressional attention on lingering problems of fraud and abuse in the so-called Medigap market."

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Conferees set to begin work on catastrophic-costs bill. Congressional Quarterly weekly report, v. 46, Feb. 13, 1988: 313-315.

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Panel may pave way for death of catastrophic-costs law. Congressional Quarterly weekly report, v. 47, July 15, 1989: 1781-1783.

Reports that House "Ways and Means members seek ideas on how to cut premiums without jettisoning most valuable benefits."

Smith, William.

The Catastrophic Coverage Act of 1988: past proposals, current law, and future options. Washington, House Republican Research Committee, 1989. 8 p. (RRC occasional paper)

"Generally, there is a cross section of opinion about the new law among Republicans. But as the new Medicare premiums take effect, the new law may be given additional scrutiny. The following report is a short history of the early Republican proposals and the final legislation, as well as a number of options currently being discussed."

Torres-Gil, Fernando.

The Politics of catastrophic and long-term coverage. Journal of aging & social policy, v. 1, 1989: 61-86.

"The passage of the Medicare Catastrophic Coverage Act of 1988 represents a milestone in the politics of catastrophic and long-term care. The politics surrounding the passage of that bill were inextricably linked to the larger issue of long-term care and to recurrent debates over comprehensive national health care. Debates over the financing and provision of health care services have occupied U.S. society and government for 50 years."

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Seniors react to the Medicare Catastrophic Bill: equity or selfishness? Journal of aging & social policy, v. 2, no. 1, 1990: 1-8.

"The Medicare Catastrophic Coverage Act (MCCA) was a source of major controversy from its passage in 1988. Some senior citizens raised a hue and cry against its funding mechanism, editorials argued for and against the bill, and Congress finally repealed it in late 1989. The bill in my opinion was a good one, and should have been retained in its basic form."

U.S. Congress. Conference Committees, 1988.

Medicare Catastrophic Coverage Act of 1988; conference report to accompany H.R. 2470 [Medicare Catastrophic Protection Act of 1987]. Washington, G.P.O. 1988. 273 p. (Report, House, 100th Congress, 2nd session, no. 100-661)

U.S. Congress. Conference Committees, 1989.
Medicare Catastrophic Coverage Repeal Act of 1989; conference report to accompany H.R. 3607 [Medicare Catastrophic Coverage Repeal Act of 1989]. Washington, G.P.O. 1989. 23 p. (Report, House, 101st Congress, 1st session, no. 101-378)

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Commerce, Consumer Protection, and Competitiveness.
Private insurance to supplement Medicare. Hearing, 101st Congress, 1st session. Apr. 6, 1989. Washington, G.P.O., 1989. 76 p.
"Serial no. 101-20"
Looks at problems associated with Medicare Supplemental Insurance, or Medigap insurance.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Medicare and Medicaid catastrophic protection. Hearings, 100th Congress, 1st session on H.R. 2470 and H.R. 2485. Washington, G.P.O., 1988. 606 p.

U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits.
Medicare Catastrophic Protection Act. Hearing, 100th Congress, 1st session. Oct. 7, 1987. Washington, G.P.O., 1987. 201 p.
"Serial no. 100-27"

U.S. Congress. House. Committee on Rules.
Providing for the consideration of H.R. 3436 [A bill to amend the Older Americans Act of 1965 to make technical corrections]; report to accompany H. Res. 466. Washington, G.P.O. 1988. 19 p. (Report, House, 100th Congress, 2nd session, no. 100-665)

U.S. Congress. House. Committee on Ways and Means.
Background materials on health care coverage and expenses of the Medicare population including H.R. 1280/H.R. 1281, the Medicare Catastrophic Protection Acts of 1987. Washington, G.P.O., 1987. 67 p.
At head of title: 100th Congress, 1st session, Committee print, WMCP: 100-10.

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Catastrophic coverage under Medicare. Hearing, 99th Congress, 2nd session. Feb. 25, 1986. Washington, G.P.O., 1986. 264 p.
"Serial 99-55"

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Catastrophic illness expenses. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1987. 578 p.
Hearings held Jan. 29-Mar. 30, 1987.
"Serial 100-7"

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Medicare supplement insurance policies. Hearing, 101st Congress, 2nd session. Mar. 13, 1990. Washington, G.P.O., 1990. 166 p.
"Serial 101-74"

U.S. Congress. House. Select Committee on Aging.
Catastrophic health costs: broad problem demanding equally broad solution. Joint hearing before Select Committee on Aging, House of Representatives and the Special Committee on Aging, United States Senate, 100th Congress, 1st session. Vols. I and II. Jan. 28, 1987. Washington, G.P.O., 1987. 2 v. (102, 40 p.)
House Select Committee on Aging pub. nbrs. 100-618, 100-623; Senate Sepcial Committee on Aging pub. nbr. 100-2

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Catastrophic health insurance: filling the long-term care gap. Hearing, 100th Congress, 1st session. July 2, 1987. Washington, G.P.O., 1987. 107 p.

"Comm. pub. no. 100-632"

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Catastrophic insurance: how the Bowen plan fails. Hearing, 100th Congress, 1st session. Feb. 17, 1987. Washington, G.P.O., 1987. 116 p.
"Comm. pub. no. 100-615"

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Catastrophic health insurance: the Medigap crisis. Hearing, 99th Congress, 2nd session. June 25, 1986. Washington, G.P.O., 1986. 271 p.
"Comm. pub. no. 99-587"

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Catastrophic health insurance: the "Medigap" crisis; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 278 p.
At head of title: Committee print.
"Comm. pub. no. 99-576"

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Catastrophic health care coverage: mending a broken promise. Hearing, 99th Congress, 2nd session. Feb. 19, 1986. Washington, G.P.O., 1986. 90 p.
"Comm. pub. no. 99-565"

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MEDIGAP insurance: the new catastrophe. Hearing, 101st Congress, 1st session. Nov. 2, 1989. Washington, G.P.O., 1990. 120 p.
"Comm. pub. no. 101-747"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
High drug costs and older Americans: a prescription for the future. Hearing, 99th Congress, 2nd session, October 8, 1986. Washington, G.P.O., 1987. 81 p.
"Comm. pub. no. 99-610."

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Medicare Catastrophic Coverage Act. Hearing, 101st Congress, 1st session. Washington, G.P.O., 1989. 77 p.
Hearing held Mar. 6, 1989 in Cedar Rapids, Iowa.
"Comm. pub. no. 101-733"

U.S. Congress. Senate. Committee on Appropriations. Subcommittee on Departments of Labor, Health and Human Services, Education, and Related Agencies.
Medicare Catastrophic Coverage Act and long-term care. Hearing, 101st Congress, 1st session. Special hearing. Washington, G.P.O., 1989. 69 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-215)

U.S. Congress. Senate. Committee on Finance.
Catastrophic care--excess revenues. Hearing, 101st Congress, 1st session. June 1, 1989. Washington, G.P.O., 1990. 367 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-519)

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Catastrophic health insurance. Hearing, 100th Congress, 1st session. Parts 1-3. Jan. 28-Mar. 26, 1987. Washington, G.P.O., 1987. 3 v., (122, 204, 235 p.) (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-169, pts. 1-3)

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Medicare catastrophic coverage. Hearing, 101st Congress, 1st session. July 11, 1989. Washington, G.P.O., 1990. 191 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-581)

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Medicare Catastrophic Loss Prevention Act of 1987; report to accompany S. 1127. Washington, G.P.O., 1987. 83 p. (Report, Senate, 100th Congress, 1st session, no. 100-126)

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Federal Services, Post Office, and Civil Service.
Impact of proposed catastrophic health legislation on the Federal annuitant. Hearing, 100th Congress, 1st session. Sept. 23, 1987. Washington, G.P.O., 1988. 198 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-420)

U.S. Congress. Senate. Committee on Labor and Human Resources.
Catastrophic health insurance. Hearing, 100th Congress, 1st session on S. 210 to amend the Public Health Service Act to provide catastrophic health insurance coverage for elderly and disabled Americans. Apr. 8, 1987. Washington, G.P.O., 1988. 306 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-375)

U.S. Congress. Senate. Special Committee on Aging.
Catastrophic health care costs. Hearing, 100th Congress, 1st session. Jan. 26, 1987. Washington, G.P.O., 1987. 199 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-69)
"Serial no. 100-1"

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The catastrophic state of catastrophic health care coverage. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 208 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-136)
Hearing held in Birmingham, AL, Apr. 16, 1987.
"Serial no. 100-4"

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Medicare coverage of catastrophic health care costs: what do seniors need, and what do seniors want? Hearing, 101st Congress, 1st session. Oct. 10, 1989. Washington, G.P.O., 1990. 48 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-639)
"Serial no. 101-11"
Hearing held in Las Vegas, Nevada.

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Medigap insurance: cost, confusion, and criminality. Hearing, 101st Congress, 1st session. Dec. 11, 1989. Washington, G.P.O., 1990. 84 p. ( Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-681)
"Serial no. 101-15"
Hearing held in Madison, Wisconsin.

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Medigap policies: filling gaps or emptying pockets? Hearing, 101st Congress, 2nd session. Mar. 7, 1990. Washington, G.P.O., 1991. 301 p. (Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-1286)
"Serial no. 101-17"

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Prescription drug costs: the growing burden for older Americans. Hearing, 100th Congress, 1st session. August 27, 1987. Washington, G.P.O., 1988. 37 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-408.)
"Serial no. 100-12."
Hearing held in Little Rock, Arkansas.

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Prescription drugs and the elderly: the high cost of growing old. Hearing, 100th Congress, 1st session. July 20, 1987. Washington, G.P.O., 1987. 168 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-297)
"Serial no. 100-9."

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Rising medigap premiums: symptom of a failing system? Hearing, 101st Congress, 2nd session. Jan. 8, 1990. Washington, G.P.O., 1990. 90 p. (Hearing, Senate, 101st Congress, 2nd session, S. Hrg. 101-663)
"Serial no. 101-16"

U.S. Congressional Budget Office.
Subsidies under Medicare and the potential for disenrollment under a voluntary catastrophic program. Washington, Congressional Budget Office, 1989. 37 p.

"Much of the dissatisfaction expressed by [Medicare] enrollees centers on the act's financing provisions, especially its income-related (or 'supplemental') premium . . . . This paper assesses the likely responses by enrollees under two alternative proposals--one that would transfer all MCCA benefits and premiums to a separate and voluntary program, and one that would link MCCA benefits and premiums to enrollment in Part B so that MCCA premiums could be avoided only by forgoing all Part B benefits."

U.S. Dept. of Health and Human Services.
Catastrophic illness expenses; report to the President. Washington, The Department, 1986. 117 p.

Partial contents.--The current health care system and the problem of catastrophic expenses.--Coverage and risk patterns: acute care for the elderly.--Long term care for the elderly.--Coverage and risk patterns: the working age population.--Catastrophic illness coverage policy options.--More complete coverage of catastrophic illness expense for Americans: recommended strategy.

U.S. General Accounting Office.
Medicare: comparison of catastrophic health insurance proposals; briefing report to the chairman, Select Committee on Aging, House of Representatives. June 19, 1987. Washington, G.A.O., 1987. 36 p.

"GAO/HRD-87-92BR, B-226390"

"Focuses on legislative proposals to provide catastrophic coverage to Medicare beneficiaries."

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Medicare: comparison of catastrophic health insurance proposals--an update; briefing report to the Chairman, Select Committee on Aging, House of Representatives. Oct. 16, 1987. Washington, G.A.O., 1987. 44 p.

"GAO/HRD-88-19BR, B-226390"

Updates a "report comparing Medicare catastrophic health insurance proposals to include H.R. 2470 [Medicare Catastrophic Protection Act of 1987], as passed by the House on July 22, 1987 and S. 1127 [Medicare Catastrophic Loss Prevention Act of 1987], as reported by the Senate Committee on Finance on July 27, 1987."

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Medicare catastrophic: roll back of premiums on schedule; report to congressional requesters. Mar. 16, 1990. Washington, G.A.O., 1990. 10 p.

"GAO/IMTEC-90-30, B-238519"

SSA was not able to stop withholding catastrophic coverage payments between January and April 1990, and will issue two refund checks, which "may be SSA's best solution but will cost about $49 million . . . . The absence of well organized computer programs affected SSA's ability to quickly reverse the process."

.....

Medicare Catastrophic Act: estimated effects of repeal on Medigap premiums and Medicaid costs. Nov. 6, 1989. Washington, G.A.O., 1989. 9 p.

"GAO/HRD-90-48FS, B-236852"

Surveys "commercial Medicare supplemental insurance (Medigap) companies and state Medicaid agencies to obtain their estimates of the effect that repeal of the Medicare provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA) would have on Medigap premiums and Medicaid budgets."

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Medicare Catastrophic Act: options for changing financing and benefits; report to the chairman, Committee on Ways and Means, House of Representatives. Sept. 15, 1989. Washington, G.A.O., 1989. 23 p.

"GAO/HRD-89-156, B-236852"

"In summary, there are no painless ways to reduce beneficiary funding . . . . Repeal of the program would increase the federal deficit for Gramm-Rudman-Hollings (Public Law 100-119) deficit reduction purposes for the next few years."

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U.S. employees health benefits: rebate for duplicate Medicare coverage; report to congressional requesters. Mar. 23, 1989. Washington, G.A.O., 1989. 9 p.

"GAO/HRD-89-56, B-231302"

"This report provides information on duplication of benefits provided under the Federal Employees Health Benefits Program (FEHBP) and the Medicare Catastrophic Coverage Act of 1988. It also assesses whether the FEHBP rebate amount for duplicate coverage is set at an appropriate amount for 1989."

U.S. President (1981-1989 : Reagan)

Proposed legislation--"Medicare Catastrophic Illness Coverage Act"; message from the President of the United States transmitting a draft of proposed legislation to provide for Medicare Catastrophic Illness Coverage and for other purposes. Washington, G.P.O., 1987. 8 p. (Document, House, 100th Congress, 1st session, no. 100-36)

Wagner, Lynn.

AARP recovering from catastrophic defeat. Modern healthcare, v. 20, July 23, 1990: 42, 44.

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Catastrophic collapse: it is a millstone or a milestone for health policy evolution? Modern healthcare, v. 19, Oct. 20, 1989: 20-23.

What's right/wrong with the drug benefit of the Medicare Catastrophic Coverage Act: commentary. American pharmacy, v. NS29, June 1989: 39-41.

James Sammons of the American Medical Association, Dee Fenster, of the Generic Pharmaceutical Industry Association, and Gerald Mossinghoff, of the Pharmaceutical Manufacturers Association, offer comments on the 1988 version of the Medicare Catastrophic Coverage Act as it was signed into law.

## C. LONG-TERM CARE

Adams, E. Kathleen. Meiners, Mark R. Burwell, Brian O.

Asset spend-down in nursing homes. Medical care, v. 31, Jan. 1993: 1-23.

"The issue of how many elderly are affected by catastrophic nursing home expenses is a major part of the debate over if and/or how to reform long-term-care financing. Currently, there is some discussion regarding the magnitude of this catastrophic event, referred to as 'asset spend-down', among the elderly. National data suggest the magnitude is small, while state-specific studies indicate it is greater."

Arling, Greg. Hagan, Shelley. Buhaug, Harald.

The feasibility of a public-private long-term care financing plan. Medical care, v. 30, Aug. 1992: 699-717.

"In this study, the feasibility of a public-private long-term care (LTC) financing plan that would combine private LTC insurance with special Medicaid eligibility requirements was assessed. The plan would also raise the Medicaid asset limit from the current $2,000 to the value of an individual's insurance benefits. After using benefits the individual could enroll in Medicaid. Thus, insurance would substitute for asset spend-down, protecting individuals against catastrophic costs. This financing plan was analysed through a computer model that simulated lifetime LTC use for a middle-income age cohort beginning at 65 years of age."

Ball, Robert M. Bethell, Thomas N.

Because we're all in this together: the case for a national long term care insurance policy. Washington, Families U.S.A. Foundation, 1989. 118 p.

Contents.--Long term care: where we are now.--Long term care in perspective: when a problem becomes a crisis.--Medicare: a hole in the umbrella.--Medicaid: a long term care policy by default.--Private insurance: 'Why can't I just buy an insurance policy?'--Developing a long term care policy: where do we go from here?

Binstock, Robert H.

Aging, disability, and long-term care: the politics of common ground. Generations, v. 16, winter 1992: 83-88.

"Long-term-care expansion is a high priority concern of both older persons and younger disabled persons, and a relatively promising goal to pursue in the 1990s. It is only one example, however, of how the two constituencies might coalesce for effective political action. Other policy goals can be similarly pursued by translating abstract principles of mutual concern into campaigns of practical action for placing specific policy proposals on the public agenda, and working for their adoption."

Buchanan, Robert J. Madel, R. Peter. Persons, Dan.
Medicaid payment policies for nursing home care: a national survey. Health care financing review, v. 13, fall 1991: 55-72.

"This research gives a comprehensive overview of the nursing home payment methodologies used by each State Medicaid program. To present this comprehensive overview, 1988 data were collected by survey from 49 States and the District of Columbia. The literature was reviewed and integrated into the study to provide a theoretical framework to analyze the collected data. The data are organized and presented as follows: payment levels, payment methods, payment of capital-related costs, and incentives in nursing home payment. We conclude with a discussion of the impact these different methodologies have on program cost containment, quality, and recipient access."

Burke, Thomas P.
Alternatives to hospital care under employee benefit plans. Monthly labor review, v. 114, Dec. 1991: 9-15.

"As hospital costs rise, employer-provided health care plans are offering increased coverage for alternative care, such as skilled nursing services, home health care, and hospice care."

Crown, William H. Capitman, John. Leutz, Walter N.
Economic rationality, the affordability of private long-term care insurance, and the role for public policy. Gerontologist, v. 32, Aug. 1992: 478-485.

"First, we present a conceptual model of individual demand for private LTC insurance in order to identify a set of considerations influencing demand that includes, but is not limited to, the affordability of private LTC insurance. The second aims to implement the model to provide new empirical estimates of the demand for private ltc insurance."

Friedland, Robert Bruce.
Facing the costs of long-term care. Washington, Employee Benefit Research Institute, 1990. 365 p. (An EBRI-ERF policy study)

Gravelle, Jane G. Taylor, Jack.
Financing long-term care for the elderly. National tax journal, v. 42, Sept. 1989: 219-232.

Harrington, Charlene.
A national long-term care program for the United States: a caring vision. JAMA [Journal of the American Medical Association], v. 266, Dec. 4, 1991: 3023-3029.

"The financing and delivery of long-term care (LTC) need substantial reform. Many cannot afford essential services; age restrictions often arbitrarily limit access for the nonelderly, although more than a third of those needing care are under 65 years old; Medicaid, the principal third-party payer for LTC, is biased toward nursing home care and discourages independent living; informal care provided by relatives and friends, the only assistance used by 70% of those needing LTC, is neither supported nor encouraged; and insurance coverage often excludes critically important services that fall outside narrow definitions of medically necessary care. We describe an LTC program designed as an integral component of the national health program advanced by Physicians for a National Health Program. Everyone would be covered for all medically and socially necessary services under a single public plan, federally mandated and funded but administered locally."

Horkitz, Karen.
Long-term care financing and the private insurance market. Washington, Employee Benefit Research Institute, 1991. 24 p. (EBRI issue brief, no. 117)

"Aside from informal care provided in the community, the current system of financing long-term care depends on the Medicaid program and individual financing. Issues confronting this system include the potential depletion of personal assets, a bias toward institutionalization, and rules that allow relatively wealthy individuals to become eligible for Medicaid."

Hoyer, Robert G.
Private insurance: where does long-term care fit in? Caring, v. 8, Apr. 1989: 12-15.

"Private LTC insurance may never be a total solution to the LTC financing problem; but it can play an important role by protecting a significant number of people against potentially ruinous LTC costs and by giving them the freedom to choose between institutionalization and home care on the basis of their needs and preferences."

Jacobs, Bruce. Weissert, William G.
Helping protect the elderly and the public against the catastrophic costs of long-term care. Journal of policy analysis and management, v. 5, winter 1986: 378-383.

Points out that "the number of older people who require long-term care will increase steadily in the decades to come. Reverse mortgages could substantially improve the monthly budgets of those most likely to need extended care, who are also least likely to have other income and liquid assets to pay for it."

Japanese, American approaches differ on aging, long-term care. Washington, Japan Economic Institute, 1992. 19 p. (JEI report no. 14A)

"A different outlook by Japanese and Americans toward aging strongly influences preparations for life in a society that has more senior citizens. This preparedness involves financial planning by governments as well as individuals. Americans, whose fears center on the cost of care, as a whole save less than the Japanese and increasingly have looked to government to help provide financial protection for long-term care. Older Japanese--who, because of steady savings and a national health insurance program, worry somewhat less about the cost of care--instead are concerned about whether the infrastructure for caregiving is adequate."

Kemper, Peter. Murtaugh, Christopher M.
Lifetime use of nursing home care. New England journal of medicine, v. 324, Feb. 28, 1991: 595-600.

"Our projections indicate that over a lifetime, the risk of entering a nursing home and spending a long time there is substantial. With the elderly population growing, this has important implications for both medical practice and the financing of long-term care."

Kim, Howard.
Long-term care chains retrench to stem losses. Modern healthcare, v. 20, May 21, 1990: 66-76.

Korn, Kristine. Iverson, Laura Himes. Pastor, Bill.
The need to reform the long-term care system. Caring, v. 8, Aug. 1989: 42-44, 46, 48, 50-51.

"The article discusses how long-term care services are fragmented, how the system is biased toward acute care and institutionalization, and how skyrocketing health and long-term care costs cause high out-of-pocket costs for the elderly, threaten the viability of Medicare and Medicaid, and burden employers. The paper concludes with a call for long-term care reform."

Kosterlitz, Julie.
Middle-class Medicaid. National journal, v. 23, Nov. 9, 1991: 2728- 2732.

"Medicaid was designed to help the nation's poor. But with help from government and smart lawyers, relatively well-to-do Americans are finding new ways to have the program pick up their nursing-home bills."

Leutz, Walter. Abrahams, Ruby. Capitman, John.
The administration of eligibility for community long-term care. Gerontologist, v. 33, Feb. 1993: 92-104.

"Eligibility assessment systems for community long-term care vary widely across current programs funded by states and Medicaid and in proposals to expand federal funding. Improved equity and efficiency in both current and proposed programs will require better specification of eligibility criteria, timing and setting of assessments, language of assessment items, training of assessors, procedures for appeal and review, and consideration of the costs of care management. Recent research and demonstrations provide models and technology for more uniform approaches in national programs."

LifePlans, Inc.
Who buys long-term care insurance? Washington, Health Insurance Association of America, 1992. 81 p.

"Based on a national survey of persons who bought, or chose not to buy, individual or employer-sponsored long-term care insurance in 1990, it presents findings related to their socio-demographic characteristics, their attitudes about long-term care risks and private insurance, and their attitudes about various government roles in the area."

Long-term care financing. Generations, v. 14, spring 1990: whole issue (p. 2-78)

Partial contents.--Which way for long-term-care financing? by Joshua M. Wiener.--Dispelling some myths: a comparison of long-term-care financing in the U.S. & other nations.--A review of national opinion surveys.--The politics of long-term care.--Public insurance options.--State community-based care systems.--The report of the Advisory Panel on Alzheimer's Disease.--The On Lok Model: consolidating care & financing.

Mahoney, Kevin J.
Financing long-term care with limited resources of the public and private sectors. Journal of aging & social policy, v. 4, no. 1-2, 1992: 35-50.

"Under Connecticut's recently implemented public/private partnership to finance long-term care, individuals will no longer need to impoverish themselves in order to receive Medicaid assistance. To encourage those people who can afford to buy a private long-term care insurance policy to do so, the state promises to shield one dollar in assets from Medicaid 'spend-down' rules for every dollar a private policy pays out for Medicaid-covered services.

McCall, N. Knickman, J. Bauer, E.
A New approach to long-term care. Health affairs, spring 1991: 164-176.

Merrill, Jeffrey.
A test of our society: how and for whom we finance long-term care. Inquiry (Chicago), v. 29, summer 1992: 176-187.

"Financing long-term care remains an issue of great national interest, but little action. This lack of action is due to a lack of consensus regarding both what they mean by long-term care and what roles the private and public sector should play. Different solutions have been offered, some focusing on the public sector and others on the private. The reality is that financing the needed care will require participation of both sectors, as well as a redefinition of their roles that makes them complementary rather than competitive, as is now the case."

Murtaugh, Christopher M. Kemper, Peter. Spillman, Brenda C.
The Risk of nursing home use in later life. Medical care, v. 28, Oct. 1990: 952-962.

"Because individuals now turning 65 have a longer life expectancy than the persons studied, they face an even higher remaining lifetime risk of nursing home use (43%). Assuming that past utilization patterns will continue, over half of the women and almost one-third of the men turning 65 in 1990 can expect to use a nursing home sometime before they die.

The Needs of the elderly in the 21st century. Sheila R. Zedlewski, et al. Washington, Urban Institute Press; Lanham, MD, Distributed by University Press of America, 1990. 240 p. (Urban Institute report, 0897-7399; 90-5)

Pepper, Claude.

Adding indigence to injury: America's long-term insurance gap. Journal of legislation, v. 15, no. 1, 1988: 15-27.

"Hopefully, Congress will enact legislation which can help us to age in peace, free from the fear of financial devastation due to long-term illness. No one in America will go bankrupt financing such a program--but most Americans will continue to face bankruptcy without it. Could any choice be more clear?"

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Long-term care insurance: the first step towards comprehensive health insurance. Caring, v. 8, Apr. 1989: 4-8, 10.

"This nation has debated the merits of a comprehensive health care plan for over fifty years. The time has come for action--the creation of a meaningful long-term care benefit will signal an important step toward that goal."

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Long-term care insurance: the first step toward comprehensive health insurance. Journal of aging & social policy, v. 1, 1989: 9-15.

"Long-term care is alive as a political issue. It is alive as a concern of young and old alike. No one in America will go bankrupt financing a comprehensive home care program like that put forth in HR 3436--but many Americans will continue to face bankruptcy without it. This nation has debated the merits of a comprehensive health care plan for over 50 years. The time has come for action, and creation of a meaningful long-term care benefit will signal an important step toward that goal."

Polich, Cynthia L.

Financing long-term care: the role of the Federal government. Caring, v. 8, Apr. 1989: 16-19, 22-23.

"While it may be appropriate for insurance companies to develop products for the small proportion of the population who are willing and able to afford them, this does not mean that the needs of current elderly, and those people who will be unable to purchase private policies in the future, should be set aside and the need for an improved public system ignored."

Rivlin, Alice M. Wiener, Joshua M.

Caring for the disabled elderly: who will pay? Washington, Brookings Institution, 1988. 318 p.

Rowland, Diane.

Help at home: long-term care assistance for impaired elderly people living alone; a report of the Commonwealth Fund Commission on Elderly People Living Alone. Baltimore, The Commission, 1989. 72 p.

"The Commission recommends that expanded Medicare financing for home care and adult day care services be provided for the 1.6 million elderly people who are severely impaired," to supplement private alternatives.

Rubin, Rosie M. Wiener, Joshua M. Meiners, Mark R.

Private long-term care insurance. Medical care, v. 27, Feb. 1989: 182-193.

Research "results indicate 1) the potential market for private long-term care insurance is substantial, 2) moderately comprehensive long-term care policies are affordable by a significant minority of the elderly, 3) policies are considerably more affordable to those under age 65, and 4) long-term care insurance has somewhat less potential to pay for nursing home costs for high risk groups than for other elderly."

Schneider, Edward L. Guralnik, Jack M.

The aging of America: impact on health care costs. JAMA [Journal of the American Medical Association], v. 263, May 2, 1990: 2335-2340.

"The rapid growth of the oldest age groups will have a major impact on future health care costs. We use current US Census Bureau projections for the growth of our oldest age groups to project future costs for Medicare, nursing homes, dementia, and hip fractures. Without major changes in the health of our older population, these health care costs will escalate enormously, in large part as a result of the projected growth of the 'oldest old,' those aged 85 years and above."

Sharfstein, Steven S. Stoline, Anne M. Goldman, Howard H.

Psychiatric care and health insurance reform. American journal of psychiatry, v. 150, Jan. 1993: 7-18.

"Principles for a more equitable design of mental health benefits include a non-discriminatory approach; payment on the basis of service rather than diagnosis; application of cost containment for care of mental illness on the same basis as care of general medical illness; retention of the public sector as a backup system for high-cost, long-term care; encouragement of lower-cost alternatives to the hospital through the development of a continuum of care; and a recognition of the distinction between psychotherapy and medical management. All current approaches to universal health care fall short of these principles."

Somers, Anne R.

Insurance for long-term care: some definitions, problems, and guidelines for action. New England journal of medicine, v. 317, July 2, 1987: 23-29.

"The costs of long-term care should and will almost certainly continue to be met through multiple sources (including personal savings, family responsibility, private insurance, and state and local assistance), but federal leadership, standards, revenue collection, and some form of coordinating framework are essential for equitable access; adequate risk pooling, income, and benefits; continuity of care and records; and avoidance of wasteful duplication."

Somers, Anne Ramsay. Spears, Nancy L.

The continuing care retirement community: a significant option for long-term care? New York, Springer Pub. Co., 1992. 206 p.

State Perspectives on Long-Term Care Management Systems: Implications for Federal Policy: a Conference (April 4, 1991). Prepared by Health Systems Research, Inc. Washington, American Association of Retired Persons, Center on Elderly People Living Alone, 1991. 21 p. (AARP, Public Policy Institute no. 9107)

Compares State experiences in long-term care management and care management components of Federal long-term care legislative proposals.

Tilly, Jane. Stucki, Barbara R.

International perspectives on long-term care reform in the United States. New England journal of human services, v. 10, 1991: 3-12.

"Policymakers in the United States need to examine the programs other countries have implemented to combat bias toward institutionalization and the inadequacy of personal care services. A detailed evaluation of recent efforts by Australia, Japan, and Israel would provide the United States with valuable insights about the possible outcome of expanding home and community services in this country."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Commerce, Consumer Protection, and Competitiveness.
Long-term care insurance standards. Hearing, 102nd Congress, 1st session on H.R. 1206, H.R. 1916, and H.R. 2378. Oct. 24, 1991. Washington, G.P.O., 1992. 173 p.

"Bills to regulate long-term care insurance policies, to allow tax-free distributions from IRA's for purchase of long-term care insurance by certain individuals, and to establish Federal standards for long-term care insurance policies.

"Serial no. 102-87"

U.S. Congress. House. Committee on Ways and Means.
Long-term strategies for health care. Hearing, 102nd Congress, 1st session. Apr. 16-25, 1991. Washington, G.P.O., 1992. 851 p.
"Serial 102-33"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Long-term care; and proposals to improve Medicare's skilled nursing facility and home health benefits. Hearing, 102nd Congress, 1st session. Mar. 4, 1991. Washington, G.P.O., 1991. 153 p.
"Serial 102-15"

Includes H.R. 651, the comprehensive MediPlan Long-Term Care Act of 1991 and incremental proposals to improve these benefits.

U.S. Congress. House. Select Committee on Aging.
Long-term care: a New Jersey perspective. Hearing, 100th Congress, 2nd session. Washington, G.P.O., 1988. 78 p.
Hearing held Apr. 22, 1988, Dunellen, NJ.
"Comm. pub. no. 100-657"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
The nation's health care crisis: the long-term care gap. Hearing, 102nd Congress, 1st session. Oct. 28, 1991. Washington, G.P.O., 1992. 49 p.
Hearing held in Boston, Mass.
"Comm. pub. no. 102-857"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
The nation's long-term health care crisis. Hearing, 102nd Congress, 2nd session. Apr. 24, 1992. Washington, G.P.O., 1992. 83 p.
"Comm. pub. no. 102-869"
Hearing held in Cleveland, Ohio.

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Private long-term care insurance: unfit for sale?; a report. Washington, G.P.O., 1989. 23 p.
At head of title: committee print.
"Comm. pub. no. 101-714"

Presents results of GAO's investigation of the "adequacy of long-term are insurance and its ability to provide a hedge against the bankruptcy cost of a long term-illness." Examines the extent that states have established minimum standards for the regulation of long-term care insurance.

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Reductions in long-term care services: a survey of States; a survey presented by the Chairmen of the House Select Committee on Aging and its Subcommittee on Health and Long-term Care and Subcommittee on Aging of the Senate Committee on Labor and Human Resources, 102nd Congress, 2nd session. Washington, G.P.O., 1992. 11 p.

At head of title: Committee print.

"Comm. pub. no. 102-866"

U.S. Congress. Senate. Committee on Finance. Subcommittee on Medicare and Long-Term Care.
Challenge of providing long-term health care. Hearing, 102nd Congress, 2nd session. May 13, 1992. Washington, G.P.O., 1992. 120 p. (Hearing, Senate, 102nd Congress, 2nd session, S. Hrg. 102-878)

Hearing addresses "an overview of the long-term care problem," for "11 million American adults and children who have the disabilities and illnesses that require long-term care."

U.S. Congress. Senate. Committee on Labor and Human Resources.
Public/private partnerships: innovative approaches to long-term care. Hearing, 101st Congress, 1st session. Jan. 17, 1[illegible]. Washington, G.P.O., 1990. 133 p. (Hearing, Senate, 101st Congress, 1st session, S. Hrg. 101-539)

Hearing held in Indianapolis, IN.

U.S. Congress. Senate. Pepper Commission.
Long-term care and access to health care: examining the scope of the problems. Hearing, 101st Congress, 1st session. Part 7. Sept. 21, 1989. Washington, G.P.O., 1990. 209 p.

Weissert, William G. Musliner, Melissa C.
Access, quality and cost consequences of case-mix adjusted reimbursement for nursing homes: a critical review of the evidence. Washington Center on Elderly People Living Alone, American Association of Retired Persons, 1992. 67 p. (AARP Public Policy Institute no. 9109)

Partial contents.--Design considerations in case-mix classification.--The Health Care Financing Administration case-mix demonstration.--Overview of State systems.--Evaluation of specific systems Illinois, Maryland, Minnesota, New York, Ohio, West Virginia, San Diego.--Conclusions and recommendations.--Resource utilization groups.--Hospital-to-nursing home discharge delays.

# How Can the Federal Government Increase Access to Health Care to United States Citizens?

A Guide to Information Sources on the
1993-1994 High School Debate Topic

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April 1993

(535)

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# A GUIDE TO INFORMATION SOURCES
# on the 1993-1994 High School Debate Topic

## INTRODUCTION

This research guide identifies sources of information on U.S. health care and related topics that will be discussed by high school debaters. It describes reference and research tools and suggests particular search strategies that can be used to retrieve information on these topics. The guide is divided into two parts: the first part describes basic research materials, and the second describes specialized materials relating to the issue of health care.

In some cases, search terms are provided for each resolution of the debate topic. In other cases, only a few general terms on the topic are provided. These search terms are not exhaustive. The primary terms are included to help the debaters begin their search for supporting materials on the range of issues relating to health care.

The individual topics are closely linked. As debaters focus on individual resolutions, and on the general issue of health care, they will also need to scan selected relevant search terms listed under the other resolutions.

In this guide, the resolutions are referred to in the abbreviated form listed below in parentheses following each resolution.

NATIONAL HEALTH CARE: How can the Federal Government increase access to health care to United States citizens? **(General)**

> Resolved: That the Federal Government should guarantee comprehensive national health insurance to all United States citizens. **(Health insurance)**
>
> Resolved: That the Federal Government should control health care costs for all United States citizens. **(Medical economics)**
>
> Resolved: That the Federal Government should guarantee catastrophic health insurance to all United States citizens. **(Catastrophic health care)**

Although printed sources are emphasized in this guide, debaters should also take note of the Federal and nongovernmental organizations listed in the guide. These offices may be able to furnish additional information or publications on various policy options.

## RESEARCH SOURCES

This is a list of key information resources described in this guide, and the page where each is described.

Academic American Encyclopedia ... 6
AgeLine ... 19
AIDSLine ... 19
American Statistics Index (ASI) ... 13
Bell and Howell Newspaper Indexes ... 9
Books in Print ... 6
BRS ... 10
Business Periodicals Index ... 8
CIS Index ... 13
Congressional Index ... 13
Congressional Quarterly Weekly Report ... 12
Congressional Record ... 12
Current Law Index ... 8
DataTimes ... 10
Depository Libraries ... 11
DIALOG ... 10
Directory of Directories ... 6
Encyclopedia Americana ... 6
Encyclopedia of Associations ... 6
Federal Depository Library Program ... 11
Federal Government Agencies ... 22
Federal Register ... 12
Government Reports Announcements and Index ... 11
Health Periodicals Database ... 19
Health Planning and Administration ... 19
Index To Legal Periodicals ... 8
Index to U.S. Government Periodicals ... 12
Infotrac II ... 11
Legislation Introduced in the 103rd Congress ... 24
Library of Congress Subject Headings ... 5
Magazine Index ... 7
Magazines and Journals on Health Care ... 20
Mental Health Abstracts ... 19
Monthly Catalog of United States Government Publications ... 11
National Journal ... 12
National Newspaper Index (microfilm) ... 9
New York Times Index ... 9
Newsletters ... 20
NEWSNET ... 10
NEXIS/LEXIS ... 10
NTIS (National Technical Information Service) ... 19
Official Washington Post Index ... 9
Organizations interested in health care reform ... 28
President's Task Force on Health Care Reform ... 21
Public Affairs Information Service (PAIS) ... 8
Reader's Guide To Periodical Literature ... 8
Sears List of Subject Headings ... 5
Social Science Citation Index ... 19
Social Sciences Index ... 20
Statistical Abstract of the United States ... 13
Statistical Reference Index ... 13
University Microfilms Newspaper Indexes ... 9
VUTEXT ... 10
Wall Street Journal Index ... 9
Weekly Compilation of Presidential Documents ... 11
WilsonLine ... 10
World Book Encyclopedia ... 6

## PART I: GENERAL REFERENCE SOURCES

### BOOKS

Many libraries around the country, particularly large academic and research libraries, use Library of Congress classification numbers to organize their collections, and Library of Congress subject headings in their catalogs. To learn how books on health care are categorized in these libraries, consult the four-volume guide, *Library of Congress Subject Headings*. It is usually kept near the card catalog, or near the terminals for an automated catalog. The most relevant LC subject headings for research on health care are listed below:

**General:**

Child health services
Delivery of health care
Health planning
Health services accessibility
Medical care
Medical laws and legislation
Medical personnel
Mental health
Minorities--Medical care
Poor--Medical care
Right to health care
Rural health
Rural health services
Rural hospitals
Socially disadvantaged--Medical care
Teenagers--Medical care
Women's health services

**I: Health insurance:**

Children--U.S.--Insurance requirements
Health maintenance organizations
Health policy
Insurance, health
Insurance, health--Government policy
Insurance, health--Law and legislation
Medicaid
Medical policy
Medical policy--U.S.--Business community participation
Medically uninsured persons
Social medicine
Teenagers--U.S.--Insurance requirements
Women--U.S.--Insurance requirements

**II: Medical economics**

Health care rationing
Medical care--U.S.--Cost control
Medical care, Cost of
Medical economics
Medical malpractice
Medical technology
Pharmaceutical industry
Quality of health care

**III: Catastrophic health care**

Aged--Medical care
Insurance, Catastrophic health
Long-term care of the sick
Medicare

In many school and public libraries, books are arranged by the Dewey Decimal classification system. In these libraries, books are usually assigned subject headings from the *Sears List of Subject Headings*, also generally found near the card catalog. The most relevant terms from this resource are:

Elderly--Medical care
Health insurance
Long-term care facilities
Medicaid
Medical care
Medical care--Costs
Medical economics
Medical technology
Medicare
Medicine--Law and legislation
Physicians--Malpractice
Social medicine

Many books on health care are assigned the Dewey Decimal number of 362.1

If you have trouble locating books that are listed here or in other bibliographic sources, ask your librarian about *Books in Print* and about interlibrary loan. *Books in Print* will be useful in identifying the addresses of publishers for the purchase of materials, and in identifying additional and recently published books. Look particularly under the terms:

Health maintenance organizations
Insurance, health
Medicaid
Medical care
Medical economics
Medical laws and legislation
Medical policy
Medicare
Medigap

Interlibrary loan may make it possible for your library to borrow materials you have identified, but that your library does not have available, from other libraries. The specialized catalog, *Medical and Health Care Books and Serials in Print*, will also be very useful for researching this topic.

## ENCYCLOPEDIAS AND DIRECTORIES

### Encyclopedia articles

Articles appear in *World Book Encyclopedia* under Health, Health care plans, and Health insurance, National. The *Encyclopedia Americana* has related entries for health care under Health and social welfare, Health insurance, Medicaid and Medicare. The *Academic American Encyclopedia* has articles on Health-care systems, Health insurance, Health-maintenance organizations, Medicaid, Medical ethics, Medicare and the Pharmaceutical industry. The *Encyclopedica Britannica's Macropedia* has an article on Medicine that discusses health care. 1992 editions were consulted.

### Encyclopedia of Associations

This annual reference source includes information on over 30,000 national and international organizations. The *Encyclopedia of Associations* consists of three volumes: the first volume, which has three parts, includes descriptive entries, as well as subject, name, and keyword indexes; the second volume contains indexes allowing searches by geographic location or executive officers' surnames; and the third volume has information on newly formed and newly founded associations. This reference source can be used to locate a variety of nonprofit, nongovernmental organizations in the area of health care.

A companion volume is the *Encyclopedia of Associations--International Organizations*. This work provides information on over "9,000 international nonprofit membership organizations, including multinational and binational groups and national organizations based outside the United States, concerned with all subjects and areas of activity." Part 1 is comprised of descriptive listings and Part 2 is indexes.

### Directory of Directories

This publication serves as a guide to the many catalogs, encyclopedias, checklists, and other compilations of information that exist in print. Any publication which includes addresses of individuals or organizations is eligible for inclusion in this resource. It lists a wide range of publications, including lists of cultural institutions, directories of professional organizations and societies, and membership lists of a variety of special interest groups. This resource can be used to locate more specialized directories of organizations and individuals involved in the field of health care. Entries are grouped by subject categories, and the publication includes a title and a subject index.

**American Library Directory 1992-93**

Edited and compiled by R. R. Bowker, this directory lists public, academic, government and special libraries in the United States, and regions administered by it, and in Canada. Arranged geographically, the entries are alphabetized by State, region, or province; then by city; and finally by the institution or library name. Entries include the name and address of the library, names of key personnel and information on the library's holdings. In addition, most entries provide information on some or all of these additional areas: income; expenditures, including salaries; subject interests; special collections; automation and publication.

## JOURNAL ARTICLES

Citations to journal articles and other materials about health care can be found in a number of printed indexes and online bibliographic databases.

The materials covered by selected printed indexes are briefly described here, along with recommended search terms for each. Printed indexes include lists of periodicals indexed and the abbreviations referring to these publications.

Online bibliographic databases are useful for locating citations to journal articles and other materials quickly through use of a computer. Online databases allow the researcher to combine search terms in ways that are impossible in a printed index or library catalog, and to simultaneously search material that would be contained in separate printed indexes covering several years. They also are updated more frequently than most printed tools. Many of the printed indexes described in this guide are also available as online databases.

Brief descriptions of some major online services providing access to bibliographic databases are provided. A reference librarian can advise you on the availability of computerized search services in your area; there is often a fee for the use of these services.

Periodicals cited frequently in the bibliography, or with titles focused particulary on the topic, may be useful to examine for the most recent articles even before they appear in the indexes. Newsletters and publications or accessions lists from private organizations may be available for purchase or subscription. Some newsletters may be available free, yet most involve a fee. For newsletters, consult *Newsletters in Print* or *The Oxbridge Directory of Newsletters*.

Weekly news sources include *Newsweek*, *Senior Scholastic*, *Time*, and *US News & World Report*; monthly/quarterly general sources include *Atlantic Monthly*, *Harpers*, *Reader's Digest* and law journals.

Selected periodicals in the health care field are listed on page 20.

**Magazine Index**

*Magazine Index* provides citations to materials in over 400 popular magazines, focusing on coverage of current affairs, leisure time activities, arts, sports, and science and technology. References from the last five years are listed alphabetically by subject and author in one alphabetical display on the *Magazine Index* microfilm reader-terminal. The index is updated monthly, and uses Library of Congress subject headings.

### Public Affairs Information Service (PAIS)

*PAIS* is a subject index of books, pamphlets, Government publications, reports of public and private agencies, and periodical articles relating to political, economic, and social conditions, public administration, and international affairs. It is issued monthly; there are also three quarterly cumulations and an annual bound volume with an author index. Some search terms in *PAIS* include:

Drug trade
Health maintenance organizations
Health planning
Insurance, health
Medicaid program
Medical service
Medical service, rural
Medical technology
Medicare
Mental health
Preferred provider organizations
Public health

### Reader's Guide to Periodical Literature

The *Reader's Guide* is an author/subject index to over 180 periodicals of general interest published in the United States and Canada. It is published twice a month from September through December and in March, April, and June. It appears monthly in January, February, May, July, and August. Library of Congress subject headings are used to organize materials. The quarterly and annual cumulations can expedite your search of this index. Selected terms on health care used in the *Reader's Guide* include:

Aged--Medical care
Drug industry
Insurance, health
Managed care plans
Medical care
Medical care--Costs
Medical care rationing
Medical care, rural
Medical policy
Physicians--Malpractice
Poor--Medical care

### Index to Legal Periodicals

The *Index* lists articles "of high quality and permanent reference value" in legal periodicals published in the United States, Canada, Great Britain, and other English language countries. The articles are indexed under author and subject. A complete list of subjects is included at the front of each bound volume. Useful search terms are:

Food drug cosmetic law
Health care industry
Health insurance
Medicaid
Medical ethics
Medical malpractice
Medical profession
Medical technology
Medicare
Nursing homes

### Current Law Index

The American Association of Law Libraries sponsors this index of articles in legal periodicals. Separate subject and author indexes and tables of cases and of statutes are included in eight monthly issues, three quarterly cumulations, and a cumulative annual. Library of Congress subject headings are the search terms used primarily.

### Business Periodicals Index

Articles from over 300 business periodicals are listed in this index. It is published monthly, except for August, and a bound cumulation is issued each year. A wide range of business publications, such as *Barrons* and the *Economist* are indexed here. Use Library of Congress subject headings to search, along with the cross-references provided in the index.

## NEWSPAPER ARTICLES

### New York Times Index

The *New York Times Index* provides extensive abstracts for articles appearing in the *New York Times*. It is issued twice a month, with quarterly and annual cumulations. Consult "How to use the New York Times Index" in the index volume itself for guidance. Some useful terms include:

Drugs (Pharmaceuticals)
Health insurance
Medicaid
Medicare
Medicine and health
Mental health and disorders
Nursing homes
Pharmaceutical industry

### Official Washington Post Index

The *Index* provides access to all substantial newsworthy items in the *Washington Post*, excluding wire service articles. It is issued monthly and cumulated annually. Some useful search terms include:

Health
Health care
Health care expenditures
Health care for the homeless
Health care industry
Health insurance
Health maintenance organizations--HMOs
Hospitals
Longterm health care
Medicaid
Medical malpractice
Medical technology
Medicare
Nursing homes
Pharmaceutical industry
Physicians
Public health

### Wall Street Journal Index

The *Wall Street Journal Index* is issued monthly and has annual cumulations. Relevant search terms are:

Health care
Health care expenditures
Health care policy
Heatlh insurance
Health maintenance organizations--HMOs
Medicaid
Medicare
Nursing homes

### National Newspaper Index (microfilm)

*National Newspaper Index* indexes the *Christian Science Monitor*, *Los Angeles Times*, *New York Times*, *Wall Street Journal*, and *Washington Post*. References from the last five years are listed alphabetically by subject headings.

### Other Newspaper Indexes

Bell & Howell Co. produces a set of indexes which list articles appearing in the *Boston Globe*, *Christian Science Monitor*, *Denver Post*, *Detroit News*, *Houston Post*, *Los Angeles Times*, *New Orleans Times-Picayune*, *San Francisco Chronicle*, *St. Louis Post-Dispatch*, and *USA Today*. University Microfilms Newspaper Indexes produces monthly and annual indexes for the *Atlanta Constitution*, *Atlanta Journal*, *Chicago Tribune*, *Los Angeles Times*, and the *Minneapolis Star and Tribune*. In addition, many newspapers are indexed locally; ask a librarian about indexes to your local newspaper.

## ONLINE DATABASES

Many libraries now have access to computerized versions of printed indexes. The information is stored in databases that can be accessed through personal computers. The advantages of using these computerized databases are search speed and flexibility; the disadvantages are the often high costs charged for access. Check with your local reference librarian to determine availability and cost of the systems listed below.

### BRS

BRS is an online service providing primarily bibliographic information. The service offers access to information in the fields of science, social sciences, business, health and related areas. BRS provides databases that are online versions of *Current Law Index* (called *Legal Resources Index*), *Magazine Index*, *National Newspaper Index*, *PAIS*, and *Reader's Guide*. Specialized health care databases are also available.

### DIALOG

DIALOG Information Service is an online service that includes a wide variety of databases, ranging from newspaper and journal indexes through statistical references and airline information. Some of the indexes available on DIALOG include online versions of the *National Newspaper Index*, *Washington Post*, AP and UPI newswires, *Magazine Index* (with full-text of some articles). DIALOG provides databases that are online versions of *Current Law Index* (*Legal Resources Index*), *National Newspaper Index* and *PAIS*. Specialized health care databases are available as well.

### NEWSNET

NEWSNET includes comprehensive bibliographic data on more than 380 newsletters and other news and information services.

### NEXIS/LEXIS

NEXIS is an online search and retrieval service that contains the full text of many newspapers, including the *Christian Science Monitor*, the *New York Times*, and the *Washington Post*; full text of major wire services, including AP, UPI, and Reuters; and full text of a number of magazines, newsletters, and Government publications. LEXIS provides information on State laws and court decisions.

### VUTEXT and DataTimes

Both of these online services index local and regional newspapers for most of the major metropolitan areas in the United States.

### WilsonLine

The H. W. Wilson Company, which publishes the *Reader's Guide to Periodical Literature*, along with a number of other indexes to journal literature, has its own online service.

### CD-ROM DATABASES

Some libraries have installed CD-ROM databases as an alternative to print and online indexes. CD-ROM is a technology that allows a great deal of information to be stored on a compact disk that can be read by a personal computer. A number of indexes are available in this format, allowing searching capabilities similar to those available with online services, but without the charge per hour. Some of the indexes available in this format include *Magazine Index*, *National Newspaper Index*, and the Wilson indexes. *ABI/Inform* is also available. Consult with your local reference librarian to determine whether this service is available in your area.

### Infotrac II

This CD-ROM product provides a subject index to more than 400 popular and widely-read magazines plus the *New York Times*. Its coverage includes current affairs, people, home and leisure activities, travel, arts and entertainment, education, companies and products.

## GOVERNMENT PUBLICATIONS

### Federal Depository Library Program

This program makes Government publications available to 1400 designated depository libraries. In order to provide the greatest possible access to Government publications, depository libraries are located in each congressional district. Of this number, 50 have been designated as regional depositories. Fifty regional libraries assume the responsibility for retaining depository material permanently, and of providing inter-library loan and reference service for their regions. Copies of documents no longer available for sale by the Government can usually be found in regional Federal depository library collections. Each issue of the *Monthly Catalog of United States Government Publications* (see below) prints a current directory of these regional libraries. A directory of all depository libraries is available from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

### Government Reports Announcements and Index

Government research reports are indexed in the *Government Reports Announcements and Index*, which is issued twice a month by the National Technical Information Service (NTIS). A keyword index lists significant words from titles. The *NTIS* index is available online through commercial systems.

### Monthly Catalog of United States Government Publications

The *Monthly Catalog* lists documents issued by all branches of the Federal Government. The catalog has monthly, semiannual, and annual indexes, arranged by author, title, subject, keywords, and series/report title. It is an excellent tool for locating materials housed in depository libraries; it can also be used to obtain information about purchasing documents directly from the Superintendent of Documents at the U.S. Government Printing Office. The *Monthly Catalog* is available commercially, and through most libraries. The search terms used are the Library of Congress subject headings described in the BOOKS section of this guide.

### Weekly Compilation of Presidential Documents

This publication contains statements, messages, and other Presidential materials released by the White House during the preceding week. There are weekly, quarterly, and annual published indexes. This information is also available online commercially. *Public Papers of the Presidents of the United States* is an annual compilation of Presidential statements.

**Index to U.S. Government Periodicals**

The *Index* covers individual periodical articles published by over 100 Federal agencies, using a thesaurus created exclusively for itself.

**Federal Register**

Federal Government regulatory agencies, including Executive Departments publish daily notices and proposed and final rules and regulations. To track a particular regulation being proposed or revised, search under the particular agency's name.

## LEGISLATIVE INFORMATION

Congressional and executive department activities on U.S. policy regarding health care and programs may be monitored by searching the following printed publications.

**Congressional Quarterly Weekly Report**

This periodical provides current information on congressional activities, the status and progress of current legislation, and major policy issues. Recent articles of particular importance are indexed on the back cover of each issue. Consult this index under the heading Health/Human Services. Quarterly and annual indexes are also issued; you may find information under the headings: Health, Health care, Health insurance, Hospitals, Long-term health care, Medicaid, Medicare, Mental health, and Nursing homes. Cross references are also provided.

*Congressional Quarterly* also publishes an annual volume which cumulates material from the weekly reports. There is an index at the back of each volume, which uses similar subject headings.

**National Journal**

*National Journal* is a weekly publication containing articles on executive branch and congressional activities. Toward the end of each issue there is a page entitled "Recent Articles." Use this page as an abbreviated index, looking under the term Health and welfare. A semi-annual index is published which allows searching under more specific topics.

**Congressional Record**

The *Congressional Record* is an edited transcript of the activities on the floor of the U.S. House and Senate. An issue is published for each day that either chamber of Congress is in session. Subject and name indexes are published biweekly and cumulated annually. Search for information on this year's debate topic under the following terms: Health, Health care facilities, Insurance, and Public health service.

## BILLS AND RESOLUTIONS

### CIS Index

The *CIS Index* is produced by the Congressional Information Service, and contains abstracts of all congressional publications except the *Congressional Record*. The index is published monthly, and cumulated quarterly and annually. Each issue of the index is divided into both index and abstract portions. Search in the index section under topics such as:

Health facilities and services
Health insurance
Health maintenance organizations
Medicaid
Medical economics
Medical personnel
Medical regulation
Medical technology
Medicare
Mental health facilities and services
Pharmaceutical industry
Public health

### Congressional Index

The *Congressional Index*, published by the Commerce Clearing House, is a weekly looseleaf service providing content and status information for bills and resolutions pending in Congress. The progress of bills and resolutions is reported, from the introduction of the legislation to the final disposition.

## STATISTICAL SOURCES

### American Statistics Index (ASI)

The *American Statistics Index* indexes and describes the statistical publications of the U.S. Government, including periodicals, annuals, biennials, semi-annuals, and special publications. It provides access to statistical materials by subject, organization, name, issuing source, and title. The index is published monthly and cumulated annually. *ASI* is also available through commercial online systems.

### Statistical Abstract of the United States: National Data Book and Guide to Sources

Published by the U.S. Department of Commerce, Bureau of the Census, on an annual basis, this source includes pertinent statistical information. This publication should be available in any depository library, as well as in the reference collections of most large public or academic libraries.

### Statistical Reference Index

The *Statistical Reference Index* provides a guide and index to selected statistical reference material from non-Federal sources on a wide variety of topics. It includes the publications of trade, professional, and other non-profit associations and institutions, business organizations, commercial publishers, university and independent research centers, and State government agencies. Information can be accessed by subject, organization, name, issuing source, and/or title. The index is published monthly and cumulated annually.

# PART II: REFERENCE SOURCES ON HEALTH CARE

## REFERENCE BOOKS AND ARTICLES

1992 Green book: overview of entitlement programs. Washington, G.P.O., 1992. 1888 p.
At head of title: Committee print.
Background material and data on major programs within the jurisdiction of the Committee on Ways and Means, U.S. House of Representatives.

1992 Guide to health insurance for people with Medicare. Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Washington, U.S. Department of Health and Human Services, 1992. 31 p.

Aging America: trends and projections. 1991 edition. Prepared by U.S. Senate Committee on Aging, the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Administration on Aging. Washington, U.S. Department of Heatlh and Human Services, 1992. 273 p. (DHHS Publication No.(FCoA) 91-28001)

Campion, Frank D.
The AMA and U.S. health policy since 1940. Chicago, Chicago Review Press, 1984. 603 p.

Charting the future of health care: policy, politics, and public health. Edited by Jack A. Meyer and Marion Ein Lewin. Washington, American Enterprise Institute for Public Policy Research, 1987. 190 p. (American Enterprise Institute studies in health policy, 449)

Current estimates from the National Health Interview Survey, United States, 1990. Hyattsville, Md., Public Health Service, 1991. 212 p.

Eighth report to the President and Congress, on the status of health personnel in the United States. Rockville, Md., Bureau of Health Professionals, 1992. 281 p.

The Future of children: U.S. health care for children. Center for the Future of Children, the David and Lucile Packard Foundation. Los Altos, Calif., The Center, 1992. 191 p.

Gaffney, James B.
Keys to understanding Medicare. Hauppauge, N.Y., Barron's, 1992. 168 p. (Barron's keys to retirement planning)

Hahn, B. Lefkowitz, D.
Annual expenses and sources of payment for health care services. Rockville, Md., Agency for Health Care Policy and Research, 1992. 19 p.
"Presents estimates of expenditures for health services and sources of payment by demographic and socioeconomic characteristics and insurance status of the civilian noninstitutionalized population of the United States."

Handbook on mental health policy in the United States. Edited by David A. Rochefort. New York, Greenwood Press, 1989. 546 p.
"This volume presents a collection of scholarly contributions on contemporary mental health problems, policies, programs, and services."

Health, United States, 1992. Hyattsville, Md., U.S. Department of Health and Human Services, Public Health Services, 1992. 339 p.

Health care for the homeless 1992 directory. Compiled by John Snow, Inc. Washington, HRSA, Bureau of Health Care Delivery Assistance, 1992. 176 p.
"The purpose of this directory is to provide a guide that will facilitate communication among the various programs and agencies serving the health care needs of the homeless."

Health progress in the United States: results of the 1990 objectives for the Nation. JAMA [Journal of the American Medical Association], v. 268, Nov. 11, 1992: 2545-2552.

Public Health Service and other physicians review the nation's progress toward health goals and objectives set out in "Promoting Health/Preventing Disease: Objectives for the Nation," 1980, and describes the relationship to the current objectives found in "Healthy People 2000."

Health status of minorities and low-income groups: third edition. Washington, U.S. Health Resources and Services Administration, Bureau of Health Professions, Division of Disadvantaged Assistance, for sale by the Supt. of Docs., G.P.O., 1991. 375 p.

Contents.--Introduction.--Vital statistics.--Prevention.--Reproductive health.--Chronic and acute disease conditions.--Injuries.--Human immunodeficiency virus infection.--Dental health.--Mental health.--Health of older Americans.--Utilization of health services.--Health insurance coverage and health care expenditures.

Health status of the disadvantaged, chartbook 1990. Washington, U.S. Dept. of Health & Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Disadvantaged Assistance. For sale by the Supt. of Docs., G.P.O., [1990] 147 p. (DHHS publication; no. (HRSA) HRS-P-DV 90-1)

Healthy people 2000: national health promotion and disease prevention objectives. U.S. Department of Health and Human Services, Public Health Service. Boston, Jones and Bartlett [1992] 153 p. (The Jones and Bartlett series in health sciences; DHHS publication, no. (PHS) 91-50212)

Summary report. Reprinted, with an added preface, from a Dept. of Health and Human Services publication in series: Publication no. (PHS) 91-50213.

Healthy people 2000: national health promotion and disease prevention objectives: full report, with commentary. Boston, Jones and Bartlett, 1992. 692 p. (The Jones and Bartlett series in health sciences; DHHS publication, no. (PHS) 91-50213)

Reprint. Originally published: Washington, D.C. : U.S. Dept. of Health and Human Services, Public Health Service : For sale by the Supt. of Docs., U.S. G.P.O., 1990. (DHHS publication ; no. (PHS) 91-50213).

HMO/PPO directory, 1992: U.S. managed healthcare organizations in detail prlus key decisionmakers. Montvale, N.J., Medical Economics Data, 1991. Various pagings.

Hospital statistics, 1992-93 edition. Chicago, The American Hospital Association, 1992. 275 p.

The International handbook of health-care systems. Edited by Richard B. Saltman. New York, Greenwood Press, 1988. 403 p.

Kemper, Vicki. Novak, Viveca.

A plague on both their houses. Common Cause magazine, v. 17, Oct. 1991: whole issue (43 p.)

Charges that comprehensive health care reform is being stymied by the activities of medical industry PACs--political action committees associated with medical associations, health insurance companies, pharmaceutical companies, and hospitals and other care providers. Includes a separate report by Common Cause showing that these PACs gave over $60 million to House and Senate candidates, including $43 million to current members of Congress from Jan. 1, 1981 through June 30, 1991.

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What's blocking health care reform? Common Cause magazine, v. 18, Jan.-Feb. 1992: 8-13, 25.

"For all the finger-pointing, few in Washington are willing to blame what may be the biggest culprit of all: the political influence of special interest groups with a vested interest in the status quo. The same insurance companies, doctors, hospitals and drug manufacturers that live off the $700 billion-a-year health care industry are battling comprehensive reform on Capitol Hill and at the White House."

Loprest, Pamela. Gates, Michael.
State-level data book on health care access and financing. Washington, Urban Institute Press; Lanham, Md., Distributed by University Press of America, 1993.
This book will be available later in 1993.

Medicaid source book: background data and analysis (a 1993 update); a report prepared by the Congressional Research Service for the use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives. Washington, G.P.O., 1993. 1127 p.
At head of title: 103d Congress, 1st session, committee print, 103-A.
Revision of the 1988 "Yellow Book."
Partial contents.--The future of Medicaid.--Trends in Medicaid payments and beneficiaries.--Eligibility.--Services.--Reimbursement.--Alternative delivery options and waiver programs.--Financing.--Recent legislative history.--Medicaid, the poor, and health insurance.--Maternal and child health.--Long-term care and the elderly.--Services for persons with developmental disabilities.--The mentally ill.--Substance abuse treatment.--Managed care.--Measures of performance.--HIV disease.

The Medicare handbook. Baltimore, Md., U.S. Dept. of Health and Human Services, Health Care Financing Administration. Washington, for sale by the Supt. of Docs., G.P.O., 1992. 52 p.

Office of Disease Prevention and Health Promotion. National Health Information Center. Health information sources in the Federal Government. Fifth edition. Washington, U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, 1990. 61 p.

Pathways to health: the role of social factors. Edited by John P. Bunker, Deanna S. Gomby, and Barbara H. Kehrer. Menlo Park, Calif., Henry J. Kaiser Family Foundation, 1989. 420 p.
Papers presented at a multidisciplinary conference organized by the Kaiser Family Foundation and held in Menlo Park, Calif. on Mar. 25-27, 1987.

Physicians' medicare guide: in one volume. By CCH Business Law Editors in cooperation with the American Medical Association. Chicago, Ill., Commerce Clearing House, 1992. 1 v. (various pagings)
"Payment schedules, claims and appeals, covered services, PROs/penalties."

Piacentini, Joseph S. Foley, Jill D.
EBRI databook on employee benefits. Edited by Carolyn Piucci and Deborah Holmes; produced by Cindy O'Connor. 2nd ed. Washington, Employee Benefit Research Institute, 1992. 559 p.
"An EBRI-ERF publication."

Roback, Gene. Randolph, Lillian. Seidman, Bradley.
Physician characteristics and distribution in the U.S. 1992 ed. Chicago, American Medical Association, 1992. 283 p.
"Contains historical and current data on the U.S. physician population that provides a basis for comparison essential for health services research, program planning, and policy development."

Romer, Milton Irwin.
National health systems of the world. New York, Oxford University Press, 1991. 1 v.

Source book of health insurance data. Health Insurance Institute, New York. Washington, Health Insurance Association of America, 1992. 141 p.

Trends in health benefits. Washington, U.S. Department of Labor, 1993. 353 p.

Universal healthcare almanac. Phoenix, Ariz., R-C Publications, 1993. Various pagings.
Contents.--National healthcare expenditures.--Hospitals.--Health maintenance organizations.--Diagnosis related group (DRG) studies.--Medicare/Medicaid.--Health insurance.--Health professionals/Manpower.--Personal healthcare expenditures.--Long-term care.--International.--Selected vital statistics and demographics.--Economic

indicators.

U.S. Congress. House. Committee on Ways and Means.
Health care resource book. Revised Jan. 1993. Washington, G.P.O., 1993. 132 p.

U.S. industrial outlook 1993. Washington, U.S. International Trade Association, 1993.
Partial contents.--Health and medical services.--Drugs and biotechnology.--Medical and dental instruments and supplies.

Women, health, and medicine in America: a historical handbook. Edited by Rima D. Apple. New Brunswick, Rutgers University Press, 1992. 572 p.
Includes bibliography.

## BIBLIOGRAPHIES

Buchanan, Jim.
Medicaid in the 1980's: a bibliography of sources. Monticello, Ill., Vance Bibliographies [1988] 24 p. (Public administration series--bibliography, 0193-970X; P 2467)

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Medicare--safety net or sinkhole: a bibliography of resources. Monticello, Ill., Vance Bibliographies [1988] 33 p. (Public administration series--bibliography, 0193-970X; P 2423)

Buss, Terry F.
Indigent care: a bibliography of policies and programs for the 1980's. Monticello, Ill., Vance Bibliographies [1988] 13 p. (Public administration series--bibliography, 0193-970X; P 2388)

Casper, Dale E.
Health and government action: a world view, 1983-1987. Monticello, Ill., Vance Bibliographies [1988] 10 p. (Public administration series--bibliography, 0193-970X; P 2332)

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National public health policy in the United States: journal articles, 1983-1988. Monticello, Ill., Vance Bibliographies [1989] 7 p. (Public administration series--bibliography, 0193-970X; P 2606)

Crumpler, Kathleen S.
Rural health care services in the United States: a bibliography. Monticello, Ill., Vance Bibliographies [1989] 22 p. (Public administration series--bibliography, 0193-970X; P 2713)

Dubow, Joyce.
Medicaid and prepayment: a bibliographic essay. Rockville, [Md.], U.S. Dept. of Health & Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery Assistance [1988] 90 p.
"Updates and supplements an earlier version Medicaid beneficiaries in health maintenance organizations."

John, Patricia LaCaille.
Health care in rural America: January 1979 - September 1991. Beltsville, Md., National Agricultural Library [1991] 67 p.
Quick bibliography series, 1052-5378; QB 92-13

Kapp, Marshall B.
Ethical aspects of health care for the elderly: an annotated bibliography. Westport, Conn., Greenwood Press, 1992. 175 p. (Bibliographies and indexes in gerontology, 0743-7560; no. 17)

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Legal aspects of health care for the elderly: an annotated bibliography. New York, Greenwood Press, 1988. 166 p. (Bibliographies and indexes in gerontology, 0743-7560; no. 7)

Rector, Rebecca.
Continuing care retirement communities and the life care industry: an annotated bibliography. Monticello, Ill., Vance Bibliographies [1988] 9 p. (Public administration series--bibliography, 0193-970X; P 2481)

Ropes, Linda Brubaker.
Health care crisis in America: a reference handbook. Santa Barbara, Calif., ABC-CLIO, 1991. 172 p. (Contemporary world issues)

Silverstein, Ben.
Medicare, law and legislation: a monographic bibliography. Monticello, Ill., Vance Bibliographies [1988] 8 p. (Public administration series--bibliography, 0193-970X; P-2553)

Walker, Elinor.
Quality-of-care research: annotated bibliography. Rockville, Md., U.S. Dept. of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research [1992] 150 p. (AHCPR publication; no. 92-0029)
At head of title: Center for General Health Services Extramural Research.

## INDEXES, ABSTRACTS, AND CONTENTS SERVICES

### AGELINE

"This online database is produced by the American Association of Retired Persons and provides bibliographic coverage of social gerontology - the study of aging in social, psychological, health-related, and economic contexts. The delivery of health care for the older population and its associated costs and policies is particularly well covered, as are public policy, employment, and consumer research. Two-thirds of the database is composed of journal articles, while the rest is devoted to citations from books. There is no print equivalent of this database."

### AIDSLINE

This database includes articles on health policy issues concerning AIDS. Selective articles from 3,363 journals published in over 70 countries are indexed.

### HEALTH PERIODICALS DATABASE

This service provides indexing and full text of journals covering a broad range of health subjects and issues. The articles are collected from core health, fitness, and nutrition publications. It is updated weekly.

### HEALTH PLANNING AND ADMINISTRATION

"This database is produced by the U.S. National Library of Medicine, and it contains references to nonclinical literature on all aspects of health care planning and facilities, health insurance, and the aspects of financial management, personnel administration, manpower planning, and licensure and accreditation that apply to the delivery of health care. References are drawn from MEDLINE and the American Hospital Association's *Hospital Literature Index*. Documents from the National Health Planning Information Center (NHPIC) are included, as well as additional journals of special importance to the health care field."

### MENTAL HEALTH ABSTRACTS

This database cites worldwide information relating to the general topic of mental health.

### NTIS (National Technical Information Service)

This database in available commercially online. NTIS consists of Government sponsored research, development, and engineering prepared by Federal agencies, their contractors or grantees. The database includes materials from both the hard and soft sciences, including material on technological applications, business procedures and regulatory matters.

### Social Science Citation Index

This index, which covers hundreds of journals, is issued quarterly and annually. Unlike most other indexes, it does not have standard subject headings; instead, key words from an article's title are listed in the Permuterm Subject Index, and full citations are then provided in the Source Index.

### Social Sciences Index

This index, which is published quarterly and cumulated annually, gives author and title access to articles from a range of journals in the social sciences. Some of the public policy journals include articles on health care. Search the following terms:

Aged--Medical care
Chronically ill
Health facilities
Insurance, health
Managed care plans (Medical care)
Medical care
Mental health services
Rural health services

## SELECTED PERIODICALS

### Magazines and Journals on Health Care

Academic Medicine: Journal of the Association of American Medical Colleges
AJN: American Journal of Nursing
American Journal of Law and Medicine
American Journal of Public Health
Business & Health
Caring
Consumers' Research
Frontiers of Health Management Services
Health Affairs: the Quarterly Journal of the Health Sphere
Health/PAC Bulletin
Health Care Financing Review
Health Economics
Health Services Review
Healthcare Financial Management
Healthcare Forum
HMQ: Health Management Quarterly
Hospital and Community Psychiatry
Hospital & Health Services Administration
Hospitals
HSR: Health Services Research
Inquiry: the Journal of Health Care Organization, Provision and Financing
International Journal of Health Planning and Management
JAMA [Journal of the American Medical Association]
Journal of Aging & Social Policy
Journal of Health and Human Resources Administration
Journal of Health Care for the Poor and Underserved
Journal of Health Economics
Journal of Health Politics, Policy and Law
Journal of Medicine and Philosophy
Journal of Occupational Medicine
Journal of Women's Health
Medical Care
Medical Care Review
Medical Economics
Medical World News
Milbank Memorial Fund Quarterly
Modern Healthcare
New England Journal of Medicine
Nursing Administration Quarterly
Private Practice
Public Health Reports
Trustee

### Newsletters

AHA News
American Medical News
"The Blue Sheet": Health Policy and Biomedical Research News of the Week
CHR (County Health Report) Newsletter
Health Care Costs
Health Legislation and Regulation
Health Professions Report
Health Security News
Health Wage Monitor
Long Term Care Management: the Independent News Source for Professionals and Providers
Managed Care Update: a Briefing on Managed Care, Health Care Costs, and Medicare/Medicaid
Medical Utilization Review: a Report on Health Care Cost Containment, PROs, Private Review, and Quality Assurance
Medicine & Health
Medicine & Health Perspectives
Policy in Perspective: Mental Health Policy Resource Center
State Health Notes: Intergovernmental Health Policy Project

## FEDERAL GOVERNMENT

### President's Task Force on Health Care Reform

On January 25, 1993, President Clinton "announced the formation of a taskforce to develop legislation for comprehensive health care reform." In early May, the President will present his health care proposal to Congress. For information on the taskforce, you can write to:

President's Task Force on Health Care Reform
Old Executive Office Building
Washington, D.C. 20500

As of March 26, 1993, there were approximately thirty-five groups working on the proposal. The working groups as provided by the White House are listed below.

I. New System Organization
  1. Principles and operation of purchasing cooperatives
  1A. Health plans, providers and patients in the new system
  2. Special issues in purchasing cooperatives toward and beyond
  3. Governance issues
  4. A Global budget
  5. Insurance reform

II. New System Coverage
  6. Benefits package
  7. Coverage for working families
  8. Coverage for low-income and non-working families

III. Infrastructure--Integrated Health Plans
  9. Quality measurement
  10. Information systems
  11. Malpractice and tort reform
  12. Health care workforce development

IV. Integration of Health Programs Into New System
  13. Medicare
  14. DoD
  15. Veterans
  16. Federal Employees Health Benefits Program
  16A. Other Government health programs

V. Ethical Foundations of New System
  17. .

VI. Transition to the New System / Short-term Cost Containment
  18. Accelerating new system development
  19. Short-term steps toward administrative simplification
  20. Interim cost containment

VII. Financing
  21. .

VIII. Health Policy Initiatives for Underserved Populations
  22A. High risk
  22B. Women and children
  22C. Urban/rural

IX. Mental Health
  23. Benefit package: basic and/or supplemental
  24. Substance abuse
  25. Children services
  26. Public system impact

X. Long Term Care
  27. Background
  28. Public
  29. Private
  30. Cost and revenue

XI. Economic Impact
  31. .

XII. Quantitative Analysis
  32. .

XIII. Legal Audit
  33. .

XIV. Numbers Audit
  34. .

XV. Drafting Group
  35. .

**Federal Government Agencies**

This list includes the names and addresses of some Federal agencies which may be able to provide information on issues pertaining to health care.

Department of Veterans Affairs, 810 Vermont Ave. N.W., Washington, D.C. 20420

Health and Human Services Dept., 200 Independence Ave. S.W., Washington, D.C. 20201

Health Care Financing Administration, 6325 Security Blvd, Baltimore, MD 21207

Health Information Center, P.O. Box 1133, Washington, D.C. 20013

National Center for Health Statistics, 6525 Belcrest Road, Hyattsville, MD 20782

Physician Payment Review Commission (Medicare), 2120 L St. N.W., Suite 510, Washington, D.C. 20037

Prospective Payment Assessment Commission (ProPAC), 300 7th St. S.W., Suite 301 B, Washington, D.C. 20024

Public Health Service, 200 Independence Ave. S.W., Washington, D.C. 20201

Agency for Health Care Policy and Research, 5600 Fishers Lane, Rockville, MD 20857

Food and Drug Administration (FDA), 5600 Fishers Lane, Rockville, MD 20857

Health Resources and Services Administration, 5600 Fishers Lane, Rockville, MD 20857

Healthy People 2000 Consortium, Office of Disease Prevention and Helath Promotion, Washington, DC 20201

## REGIONAL HHS OFFICES

Addresses of regional offices of the Department of Health and Human Services are listed below.

| *IF YOU LIVE IN:* | *REGIONAL OFFICE* |
|---|---|
| Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont | John F. Kennedy Federal Bldg.<br>Government Center<br>Boston, MA 02203 |
| New Jersey, New York, Puerto Rico, Virgin Islands | Jacob J. Javits Federal Bldg.<br>26 Federal Plaza<br>New York, NY 10278 |
| Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia | 3535 Market Street<br>Philadelphia, PA 19104 |
| Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee | 101 Marietta Tower<br>Atlanta, GA 30323 |
| Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin | 105 W. Adams Street<br>Chicago, IL 60603 |
| Arkansas, Louisiana, New Mexico, Oklahoma, Texas | 1200 Main Tower<br>Dallas, TX 75202 |
| Iowa, Kansas, Missouri, Nebraska | 601 E 12th Street<br>Kansas City, MO 64106 |
| Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming | 1961 Stout Street<br>Denver, CO 80294 |
| Arizona, California, Hawaii, Nevada, American Samoa, Guam, Trust Territory of the Pacific Islands | Federal Office Bldg.<br>50 United Nations Plaza<br>San Francisco, CA 94102 |
| Alaska, Idaho, Oregon, Washington | 2201 Sixth Ave.<br>Seattle, WA 98121 |

## Legislation Introduced in the 103rd Congress

This list contains some of the legislation introduced in the 103rd Congress which relates to this year's debate topic. Both the bill number and the sponsor are listed in boldface font. In all cases the official title is used. Bills listed here were introduced prior to March 5,1993 are included. For information on the status of bills and future bills, please refer to page 13.

### Legislation Introduced in the House of Representatives

**H.R.16 (Dingell)**
A bill to provide a program of national health insurance, and for other purposes.

**H.R.19 (Rostenkowski)**
A bill to amend title XVIII of the Social Security Act to provide for coverage of certain preventive services under part B of the Medicare program.

**H.R.21 (Rostenkowski)**
A bill to amend title XVIII of the Social Security Act to make miscellaneous and technical changes to the Medicare program.

**H.R.99 (Grandy)**
A bill to provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable, to improve and make more efficient the provision of medical and health insurance information, and to improve enforcement of requirements relating to multiple employer welfare arrangements.

**H.R.73 (Hoagland)**
A bill to require the Secretary of Health and Human Services and the Attorney General to jointly carry out a demonstration program to reduce health care cost through the sharing by medical facilities of certain services and equipment, notwithstanding any antitrust law to the contrary, and to direct the Attorney General to carry out a certificate of review process exempting eligible medical facilities from the application of certain antitrust laws.

**H.R.74 (Hoagland)**
A bill to provide for the simplification of health payor forms.

**H.R.101 (Rangel)**
A bill to improve access to health insurance and contain health care costs, and for other purposes.

**H.R.133 (Collins)**
A bill to amend the Social Security Act to protect consumers through the establishment of standards for long-term care insurance policies.

**H.R.144 (Cox, C.)**
A bill to reform the health care system by restoring the full tax deductibility of medical expenses; eliminating incentives for abusive litigation against hospitals, doctors, nurses, and health care providers; abolishing noneconomic damages in medical care liability actions; and redirecting punitive damages to community hospitals that care for the indigent.

**H.R.150 (Hastert)**
A bill to amend the Internal Revenue Code of 1986 to improve access to health care, and for other purposes.

**H.R.191 (Gekas)**
A bill to reform the United States health care delivery and financing system, to increase access to health care and affordable health insurance, to contain costs of health care in a manner that improves health care, and for other purposes.

**H.R.193 (Gunderson)**
A bill to provide for improvements to the health of farm families, and for other purposes.

**H.R.198 (Houghton)**
A bill to provide improved access to health care, and for other purposes.

**H.R.200 (Stark)**
A bill to establish the framework for a health care system that will bring about universal access to affordable, quality health care by containing the growth in health care costs through a national health budget, managed competition, and other means, by improving access to and simplifying the administration of health insurance, by deterring and prosecuting health care fraud and abuse, by expanding benefits under the Medicare program, by expanding eligibility and increasing payment levels under the Medicaid program, and by making health insurance available to all children.

**H.R.237 (LaRocco)**
A bill to increase access to health care services for individuals in rural areas, and for other purposes.

**H.R.257 (Neal, R.)**
A bill to establish a Health Care Crisis Policy Commission.

**H.R.264 (McCandless)**
A bill to amend the Internal Revenue Code of 1986 to restore the deduction for health insurance costs of self-employed individuals for an indefinite period, and to increase the amount of such deduction.

**H.R.286 (Morella)**
A bill to amend the Public Health Service Act to facilitate the entering into of cooperative agreements between hospitals for the purpose of enabling such hospitals to share expensive medical or high technology equipment or services, and for other purposes.

**H.R.405 (Solomon)**
A bill to amend the Internal Revenue Code of 1986 to allow health insurance premiums to be fully deductible to the extent not in excess of $3,000.

**H.R.438 (Wyden)**
A bill to amend title XIX of the Social Security Act to establish Federal standards for long-term care insurance policies.

**H.R.474 (Panetta)**
A bill to amend title XIX of the Social Security Act to require the coverage of hospice care under Medicaid plans.

**H.R.577 (Bereuter)**
A bill to amend the Internal Revenue Code of 1986 to increase and make permanent the deduction for the health insurance costs of self-employed individuals.

**H.R.671 (Durbin)**
A bill to establish a National Commission on Health Care Fraud and Abuse.

**H.R.679 (Holden)**
A bill to restore and increase the deduction for the health insurance costs of self-employed individuals.

**H.R.725 (Machtley)**
A bill to amend title XIX of the Social Security Act to create a new part under such title to provide access to services for medically underserved populations not currently served by federally qualified health centers, by providing funds for a new program to allow federally qualified health centers and other qualifying entities to expand such centers' and entities' capacity and to develop additional centers.

**H.R.727 (Matsui)**
A bill to amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for pregnant women and children through employment-based insurance and through a State-based health plan.

**H.R.815 (Barrett, B.)**
A bill to amend the Internal Revenue Code of 1986 to restore and increase tax deduction for the health insurance costs of self-employed individuals.

**H.R.834 (Glickman)**
A bill to provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

**H.R.836 (Hutchinson)**
A bill to amend the Internal Revenue Code of 1986 to restore and increase the deduction for the health insurance costs of self-employed individuals.

**H.R.882 (Rowland, J.)**
A bill to require the Secretary of Health and Human Services to submit to the Congress a proposal for the regulation of long-term care insurance policies, including an analysis and evaluation of such policies as are available to individuals, and to amend the Internal Revenue Code of 1986 to allow tax-free distributions from individual retirement accounts for the purchase of long-term care insurance coverage by individuals who have attained age 59 1/2.

**H.R.912 (Peterson, C.)**
A bill to amend the Internal Revenue Code of 1986 to repeal the limitation on passive activity losses and credits, provide an accelerated depreciation schedule for real estate, restore the investment tax credit, allow a deduction for certain capital gains, restore and increase the deduction for health insurance costs of self-employed individuals, restore income averaging, and reduce social security taxes and remove the ceiling on wages subject to such taxes.

**H.R.945 (Dicks)**
A bill to amend the Public Health Service Act and the Social Security Act to increase the availability of primary and preventive health care, and for other purposes.

**H.R.1038 (Byrne)**
A bill to direct the Secretary of Health and Human Services to provide Federal minimum standards for health insurance for the elderly, and to amend title XVIII of the Social Security Act for the purpose of directing the Secretary to study methods of further improving the regulation of health insurance for the elderly and to evaluate methods by which the Medicare program could more fully meet the health insurance needs of the elderly.

**H.R.1130 (Santorum)**
A bill to enable the Secretary of Health and Human Services to carry out activities to reduce waste and fraud under the Medicare program.

**H.R.1176 (Pomeroy)**
A bill to amend chapter 17 of title 38, United States Code, to establish a program of rural health-care clinics, and for other purposes.

**H.R.1200 (McDermott)**
A bill to provide for health care for every American and to control the cost of the health care system.

## Legislation Introduced in the Senate

**S.18 (Specter)**
A bill to provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

**S.28 (McCain)**
A bill to improve the health of the Nation's children, and for other purposes.

**S.190 (Helms)**
A bill to amend the Internal Revenue Code of 1986 to allow the one-time exclusion or gain from sale of a principal resident to be taken before age 55 if the taxpayer or family member suffers a catastrophic illness.

**S.203 (Kennedy)**
A bill to amend the Public Health Service Act to improve the quality of long-term care insurance through the establishment of Federal standards, and for other purposes.

**S.223 (Cohen)**
A bill to contain health care costs and increase access to affordable health care, and for other purposes.

**S.241 (Pryor)**
A bill to provide incentives to health care providers serving rural areas, to provide grants to county health departments providing preventative health services within rural areas, to establish State Health Service Corps demonstration projects, and for other purposes.

**S.325 (Kassebaum)**
A bill to provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

**S.339 (Baucus)**
A bill to amend the Internal Revenue Code of 1986 to extend for 6 months the deduction for health insurance costs of self-employed individuals.

**S.360 (Dorgan)**
A bill to amend the Internal Revenue Code of 1986 to extend the deduction for health insurance costs of self-employed individuals for an indefinite period, and to increase the amount of such dedurtion.

**S.381 (Daschle)**
A bill to amend the Internal Revenue Code of 1986 to make permanent, and to increase to 100 percent, the deduction of self-employed individuals for health insurance costs.

**S.452 (Conrad)**
A bill to amend chapter 17 of title 38, United States Code, to establish a program of rural health-care clinics, and for other purposes.

**S.491 (Wellstone)**
A bill to provide health care for every American and to control the cost of the health care system.

**S.493 (Cohen)**
A bill to amend the Public Health Service Act to facilitate the entering into of cooperative agreements between hospitals for the purpose of enabling such hospitals to share expensive medical or high technology equipment or services, and for other purposes.

**S.571 (Durenberger)**
A bill to amend the Internal Revenue Code of 1986 to permanently increase the deductible health insurance costs for self-employed individuals.

**S.572 (Durenberger)**
A bill to amend the Internal Revenue Code of 1986 to make permanent the deduction for health insurance costs for self-employed individuals.

## ORGANIZATIONS

There are many organizations interested in health care reform. Some organizations may be able to provide information by correspondence or a list of publications available for sale. The list of books which follows is a selection of the many available guides to organizations.

1993 Handbook: a directory of healthcare meetings and conventions. Atlanta, Ga., Healthcare Convention & Exhibitors Association, 1992. 81st edition. 385 p.

Clearinghouse directory, a 1991-92 guide to information clearinghouses and their resources, services, and publications. First edition. Detroit, Gale Research, 1991.

Detwiler directory of medical market sources. Warsaw, Ind., S.M. Detwiler & Associates, Inc., 1992. 304 p.

Encyclopedia of governmental advisory organizations, 1992-93. 8th edition. Detroit, MI, Gale Research Co., 1992. 2 v.

Use the name and keyword index in Volume 1, Part 3.

"A reference guide to approximately 5,000 permanent, continuing, and ad hoc U.S. presidential advisory committees, congressional advisory committees, and other agencies."

Health & medical care directory. Niagara Falls, N.Y., Yellow Pages of America, Inc., 1992. 675 p.

"The national yellow pages directory of organizations providing goods and services to the American health care industry."

The Health care 500: a complete guide to the most influential health policy makers in the in the United States, 1991. N.Y., Faulkner & Gray, Inc., 1991. 1 v.

"Document brings together information about the most influential people at the national, state, and local government level, in the sprawling health care industry, and in the academic and research institutions across the country."

Health groups in Washington: a directory. New York, National Health Council, Inc., 1992. (Government relations handbook series)

Medical & health information directory, 1992-93. Detroit, MI, Gale Research Co., 1992. 3 v.

National health directory, 1992. Gaithersburg, MD, An Aspen Publication, 1992. 643 p.

"Complete directory, including names, titles, addresses and telephone numbers of more than 11,500 'key information sources' on health programs and legislation."

The 1993 edition will be available in July.

Public policy and Catholic healthcare organizations: action steps for effective grassroots advocacy. St. Louis, MO, Catholic Health Association of the United States, 1989. 54 p.

Washington information directory, 1992-93. Washington, Congressional Quarterly. 1118 p.

This directory, which is updated yearly, lists both governmental and nongovernmental organizations with headquarters or branch offices in Washington, D.C.

Washington representatives; who does what for whom in the nation's capital, 1992. Sixteenth edition. Washington, Columbia Books, Inc., 1993.

"A compilation of Washington representatives of the major national associations, labor unions and U.S. companies, registered foreign agents, lobbyists, lawyers, law firms and special interest groups, together with their clients and areas of legislative and regulatory concern."

Some examples of the groups that are interested in health care reform are:

AFL-CIO, 815 16th St. N.W., Washington, D.C. 20006

American Academy of Family Physicians (AAFP), 2021 Mass. Ave. N.W., Washington, D.C. 20036

American Association of Nurses (ANA), 2420 Pershing Road, Kansas City, MO 64108

American Association of Retired Persons (AARP), Health Care Campaign, 1909 K St. N.W., Washington, 20049

American Dental Association, 1111 14th St. N.W., Washington, D.C. 20005

American Hospital Association (AHA), 840 N. Lake Shore Dr., Chicago, IL 60611

American Medical Association (AMA), 515 North State St., Chicago, IL 60610

American Pharmaceutical Association, 2215 Constitution Ave. N.W., Washington, D.C. 20037

BlueCross/BlueShield Association, Metropolitan Square, 655 15th St. N.W., Suite 350, Washington, D.C. 20005

Committee for National Health Insurance (CNHI), 1757 N. St. N.W., Washington, D.C. 20036

Employee Benefit Research Institute (EBRI), 2121 K St. N.W., Suite 600, Washington, D.C. 20037

Families, U.S.A., 1334 G St. N.W., Washington, D.C. 20005

Federation of American Health Systems, 1111 19th St. N.W., Washington, D.C. 20036

Group Health Association of America, Inc. (GHAA), 1129 20th St. N.W., Suite 600, Washington 20036

Health Insurance Association of America (HIAA), 1025 Connecticut Ave. N.W., Washington, 20036

Healthcare Leadership Council, 1500 K St. N.W., #350, Washington, D.C. 20005

Intergovernmental Health Policy Project (IHHP), 2011 Eye St. N.W., Washington, D.C. 20006

Kaiser Family Foundation, 2400 Sand Hill Road, Menlo Park, CA 94025

National Association of Counties, 440 1st St. N.W., Washington, D.C. 20001

National Association of Health Underwriters (NAHU), 1000 Connecticut Ave. N.W., Washington, D.C. 20036

National Association of State Mental Health Program Directors, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314

National Federation of Independent Business, 600 Maryland Ave. S.W., Suite 700, Washington, D.C. 20024

National Health Policy Forum (NHPF), 2011 Eye St. N.W., Washington, D.C. 20006

National Governors' Association, 444 N. Capitol St. N.W., Washington, D.C. 20001

National Leadership Coalition for Health Care Reform, 555 13th St. N.W., Washington, D.C. 20004

National Mental Health Association, 1021 Prince St., Alexandria, VA 22314 ON-LOCK

Project Hope, Center for Health Affairs, Two Wisconsin Circle, Suite 500, Chevy Chase, MD 20815

Public Citizen, Health Research Group, 2000 P St. N.W., Washington, D.C. 20036

Robert Wood Johnson Foundation, U.S. Route 1 & College Road East, Princeton, NJ 08543-2316

# Subject Bibliography

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## PUBLICATIONS RELATING TO THE 1993-94
## HIGH SCHOOL DEBATE TOPIC

NATIONAL HEALTH CARE: *How Can the Federal Government Increase Access to Health Care to United States Citizens?*

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___Adolescent Health, Volume 3: Crosscutting Issues in the Delivery of Health and Related Services. *Includes sections on: major issues pertaining to the delivery of health services to adolescents; financial access to health services; issues in the delivery of services to selected groups of adolescents; the role of Federal agencies in adolescent health; and burden of health problems among United States adolescents.* 1991: 312 p.; ill.
Y 3.T 22/2:2 Ad 7/2/v.3 S/N 052-003-01236-7 $13.00

___Does Health Insurance Make a Difference?, Background Paper. *Reviews the scientific literature linking health insurance status with access to and the use of health services, and with individual health outcomes.* 1992: 90 p.; ill.
Y 3.T 22/2:2 H 34/6 S/N 052-003-01301-1 5.00

___Educational Differences in Health Status and Health Care. *Presents estimates of basic health characteristics by detailed years of education, with the health characteristics including limitation of activity due to chronic conditions, restricted-activity days, respondent-assessed health status, physician contacts, short-stay hospital discharges and days, incidence of acute conditions, and prevalence of chronic conditions.* 1991: 72 p.
HE 20.6209:10/179 S/N 017-022-01147-6 4.00

___Evaluation of the Oregon Medicaid Proposal. *Examines Oregon's proposed novel health care financing program in detail. The proposed program is premised on two basic assumptions: all uninsured poor people should have publicly funded health care coverage; and coverage for the poor can be made affordable to the taxpayers through a combination of two mechanisms.* 1992: 335 p.; ill.
S/N 052-003-01297-9 17.00

___Guide to Health Insurance for People With Medicare: 1993. *Discusses: what Medicare pays and doesn't pay; types of private health insurance; tips on shopping for private health insurance; and ten standard Medigap insurance plans. Sold in packages of 50 copies only.* 1993: 35 p.
S/N 017-060-00554-8 42.00
Per Package

___Health Benefits and the Workforce. *Provides fifteen studies on the employment and health insurance of firms and workers, monitoring health insurance market practices and states legislative activities, and modeling the impact of alternative reform proposals.* 1992: 279 p.; ill.
L 1.2:H 34/6 S/N 029-000-00442-1 $14.00

___Health Care Financing Review. (Quarterly and Annual Issue.) *Contains articles relating to health care financing.* Subscription price: Domestic - $19.00 a year; Foreign - $23.75 a year. Single copy price: Domestic - $11.00 a copy; Foreign - $13.75 a copy. Annual Issue: Domestic - $6.50 a copy; Foreign - $8.12 a copy. File Code 2Q. List ID HFRQ.
HE 22.18: S/N 717-011-00000-7

___Health Care Financing Status Report: Research and Demonstrations in Health Care, 1992. 1993: 185 p.
HE 22.16/2:992 VLP 18 S/N 017-060-00555-6 11.00

___Health Care in Rural America. *Assesses the special problems in delivering health care in rural areas. These problems include: recruiting and retaining hospital personnel; difficulty in providing medical technologies that are commonly available in urban areas; and a reported increase in rural hospital closures.* 1990: 567 p.; ill.
Y 3.T 22/2:2 H 34/5 S/N 052-003-01205-7 22.00

___Health Care Resource Book, December 20, 1991. *Includes sections on: health care expenditures; health insurance; and access and outcomes.* 1991: 133 p.; ill. revised ed.
Y 4.W 36:WMCP 102-31 S/N 052-070-06788-8 6.00

___Health Insurance Coverage: 1987-1990. *Presents quarterly estimates of the extent and type of health insurance coverage (and the characteristics of those who lacked insurance) from the first quarter of 1989 to the fourth quarter of 1990. Also examines the extent to which people are covered by health insurance over a 28-month period beginning in October 1986.* 1992: 44 p.; ill.
S/N 803-044-00017-1 3.00

___Health Status of Minorities and Low-Income Groups. *Includes sections on: vital statistics; prevention; reproductive health; chronic and acute disease conditions; injuries; human immunodeficiency virus infection; dental health; mental health; health of older Americans; utilization of health services; and health insurance coverage and health care expenditures.* 1991: 380 p.; ill.
HE 20.9302:M 66/3/991 S/N 017-000-00257-1 18.00

___Health, United States, 1991, and Prevention Profile. *Provides 143 detailed tables on: health status and determinants; use of health resources; health care resources; and health care expenditures.* 1992: 347 p.; ill.
HE 20.6223:991 S/N 017-022-01156-5 18.00

___Healthy People 2000: National Health Promotion and Disease Prevention Objectives, Full Report, With Commentary. *Contains a national strategy for significantly improving the health of the Nation by the year 2000. Discusses the prevention of major chronic illnesses, injuries, and infectious diseases.* 1991: 702 p.; ill.
HE 20.2:D 63/8/report S/N 017-001-00474-0 31.00

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___Locating Resources for Healthy People 2000 Health Promotion Projects. *Lists private organizations, public agencies, and information resources that can provide resources to help achieve the goals of "Healthy People 2000." Also includes a list of acronyms, a glossary, a bibliography, and a sample grant application form.* 1991: 60 p.; ill. HE 20.2:H 34/22 S/N 017-001-00477-4 $ 3.25

___President's Comprehensive Health Reform Program, February 6, 1992. *Presents President Bush's plan for comprehensive health care reform. The plan "is a comprehensive, market-based reform that builds on the strengths of our current system to provide access to affordable health insurance for all Americans."* 1992: 96 p.; ill. Pr 41.2:H 34 S/N 041-001-00369-0 5.00

___Report on H.R. 5502, Health Care Cost Containment and Reform Act of 1992, July 22, 1992. *Discusses a bill which, if it becomes a law, would provide for health care cost containment, health systems reform, expansion of health benefits and other health initiatives, and amendments to the Medicare program.* 1992: 94 p. Y 4.W 36:WMCP 102-47 S/N 052-070-06817-5 3.25

___Selected Options for Expanding Health Insurance Coverage. *Analyzes two major approaches for substantially reducing the number of uninsured people. One would expand employment-based coverage, while the other would cover more people under Medicaid.* 1991: 101 p. Y 10.2:H 34/4 S/N 052-070-06751-9 5.50

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